JOURNAL

of the

AMERICAN PODIATRY ASSOCIATION

ANNUAL MEETING
WASHINGTON, D. C.
AUGUST 22-26, 1958

The Official Publication of the Podiatry-Chiropody Profession

Ambulatory

Fracture Cases

Diabetic Neuro-Arthropathy

Standard Schedule for Foot Surgery

Geriatric Foot Orthopedics & Pharmacy

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VOLUME 48, NUMBER 1 JANUARY, 1958

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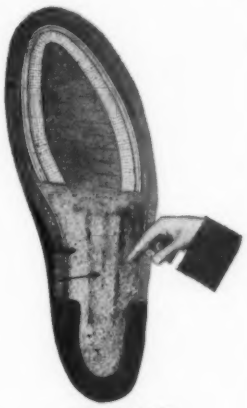

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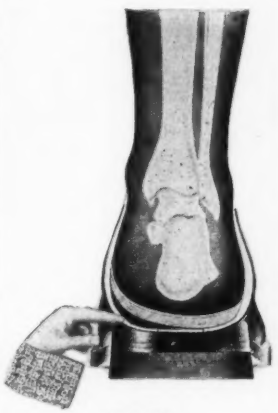

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Notice of change of address should be received six weeks before the change is to become effective. Old and new address must be given.

The *Journal of the American Podiatry Association* is published monthly and copyrighted in 1958 by the American Podiatry Association.

Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879. Publication office, 375 Broadway, Boston, and Editorial Executive offices 3301 16th St., N.W., Washington 10, D. C.

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PRE-GANGRENOUS LESIONS IN PERIPHERAL VASCULAR DISEASE.
Robert Nabatoff, M.D.

PATHODYNAMICS OF OSTEOARTHRITIS OF THE KNEE AS RELATED TO THE FEET.
Charles Plotz, M.D.

PODIATRIC PROBLEMS IN CARDIAC PATIENTS.
Milton Plotz, M.D.

SUNDAY

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TECHNIQUE OF THERAPEUTIC INJECTIONS.
H. Harvey Haber, D.S.C.

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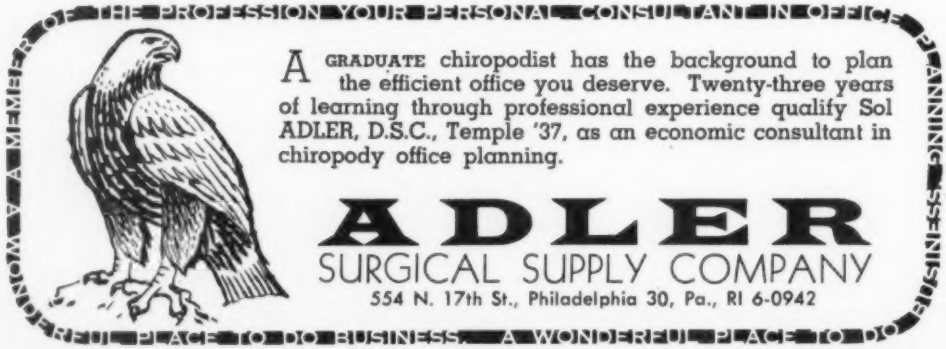
American Foot Health Foundation—Dr. Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.



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Announcement

AMERICAN COLLEGE OF FOOT SURGEONS

Scientific Conclave
will be held Feb. 17, 18, and 19, 1958
Riviera Hotel
Las Vegas, Nevada for Three Days
Scientific Sessions Half Day Only

Definite Program

Monday, Feb. 17

1. Office Surgery — **Dr. Jack M. Kohl, Chicago, Illinois**
   a. Pre- and Post-Operative Considerations
   b. Discussion of instruments, linen and sutures
   c. Procedures of forefoot surgery supplemented by slides and movies.
2. Scaphoid Surgery — **Dr. Raymond Kingland, Boise, Idaho**
   a. Pre- and Post-Operative Care
   b. Indication—Technique

Tuesday, Feb. 18

1. Calcaneal Bursitis—Calcaneal Bone Trimming — **Dr. R. Rutherford, Berkeley, California**
   a. Pre- and Post-Operative Consideration
   b. Technique
2. Hallux Valgus—Cause and Correction — **Dr. Ralph Fowler, Detroit, Michigan**
   a. Pre- and Post-Operative Care
   b. Office and Hospital Procedures

Wednesday, Feb. 19

1. Hospital Surgical Chiropody — **Dr. I. Forman, Philadelphia, Penn.**
   a. How to secure affiliation
   b. Pre- and Post-Operative Care
   c. Hospital (Chiropody) Decorum
   d. Procedure—forms, explanation, tests, etc.

All speakers are Fellows of the American College of Foot Surgeons and well-qualified in presenting their subjects.

Fellows, Associates & Applicants in Process
Registration fee $25.00

Other American Podiatry Association Members
Registration fee $35.00

STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

Alabama
The Alabama Medical Board of Examiners. **Board Secretary:** Dr. Elizabeth P. Sealy, 34 South Perry Street, Montgomery, Ala.

Arizona
The next board meeting of the Arizona State Board of Chiropody Examiners will be held for examination in Phoenix, Ariz., in Jan., 1958. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Arizona.

California
The Board of Medical Examiners of the state of California. **Executive Secretary:** Louis E. Jones.

Connecticut
The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware
The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dela.

District of Columbia
The next meeting of the Board of Podiatry Examiners of the District of Columbia will be held for examination at 1740 Massachusetts Ave., N. W., Wash., D. C., in January 1958. **Board Secretary:** Dr. Harry L. Hoffman, 1098 National Press Bldg., Washington, D. C.

Florida
The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia
The next board meeting of the Georgia State Board of Chiropody Examiners will be held for examination in June, 1958 at the State Capitol Bldg., Atlanta, Ga. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho
The Idaho State Board of Chiropody Examiners. **Board Secretary:** Dr. Alma N. Miller, 301 Kane Bldg., Pocatello, Idaho.

Illinois
The Illinois Chiropody Examining Committee. **Superintendent of Registration:** Frederic B. Seicke, Dept. of Registration and Education, Capitol Bldg., Springfield, Ill.

Iowa
The Iowa State Chiropody Board of Examiners. **Board Secretary:** Dr. C. T. Howard, Lippert Bldg., Boone, Iowa.

Kansas
The Kansas Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** L. F. Schmaus, M. D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky
The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 728 Starks Bldg., Louisville, Ky.

Maine
The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Adam P. Leighton, Jr., M.D., 192 State St., Portland, Maine; **Podiatry Examiner:** Dr. Ellsworth C. Reed, 547A Congress St., Portland, Me.

Maryland
The Maryland State Board of Examiners. **Board Secretary:** Dr. M. E. Walsh, 11 Dundalk Avenue, Dundalk 22, Md.

Massachusetts
The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at the State House, Boston, Mass. **Board Secretary:** Dr. Charles H. Thorner, Rm. 33, State House, Boston, Mass.

Minnesota
The Minnesota Board of Chiropody Examiners. **Board Secretary:** H. W. Leibold, D.S.C., 221 Hamm Bldg., St. Paul 2, Minn.

Mississippi
The Mississippi State Board of Health, **Board Secretary:** Dr. Felix J. Underwood, Old Capitol, Jackson, Miss.

Missouri
The next board meeting of the Missouri State Board of Chiropody will be held for reciprocity and examination in the Jefferson Bldg., Jefferson City, Mo., on June 14-15, 1958, **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

Montana
The next board meeting of the Montana Chiropody-Medical Board of Examiners will be held when the need arises for reciprocity or examination at the State Capitol, Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First Natl. Bank Bldg., Bozeman, Mont.

Nebraska
The next board meeting of the Nebraska State Board of Examiners in Chiropody will be held at the State Capitol Bldg., Lincoln, Nebr. in July 1958. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada
The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 Chestnut St., Reno, Nevada.

New Hampshire
The New Hampshire Board of Registration in Chiropody. **Board Secretary:** M. Atkinson, M.D., 61 S. Spring St., Concord, N. H.

New Mexico
The next board meeting of the New Mexico State Board of Chiropody will be held for reciprocity and examination on July 12-13, 1958 at Albuquerque, N. Mex. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N. E., Albuquerque, N. M.

New York
The New York State Board of Podiatry Examiners. **Board Secretary:** Mr. James O. Hoyle, 23 S. Pearl St., Albany, New York.

North Carolina
The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Dr. Charles Darby, P. O. Box 55, Statesville, N. C.

North Dakota
The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call in 1958 at 303 Black Bldg., Fargo, N. Dak. **Board Secretary:** Dr. E. B. Snuff, 303 Black Bldg., Fargo, No. Dak.

Oklahoma
The Oklahoma State Board of Chiropody. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon
Oregon State Chiropodists Examining Board. **Board Secretary:** Harold M. Erickson, M.D., 914 State Office Bldg., Portland 1, Oregon.

Pennsylvania
The next board meeting of the Pennsylvania State Board of Chiropody Examiners will be held at the Education Building, Harrisburg, Pa., on February 19, 1958. **Board Chairman:** Dr. Ralph H. Orr, 424 Colorado Drive, Erie, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. Third St., Harrisburg, Pa.

Rhode Island
The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina
The South Carolina Board of Chiropody Examiners. **Board Secretary:** Dr. Charles W. Clark, 535 Harden St. Five Points, Columbia, South Carolina.

South Dakota
The next board meeting of the South Dakota State Board of Chiropody Examiners will be held for reciprocity and examination in Sioux Falls, S. D. in June, 1958. **Board Secretary:** Dr. Fred D. Lane, 204 Kresge Bldg., Sioux Falls, S. D.

Tennessee
The Tennessee Board of Registration in Chiropody. **Board Secretary:** Dr. Arthur Richert, 3355 Poplar St., Memphis, Tenn.

Texas
The next board meeting of the Texas State Board of Chiropody Examiners will be held at the Hilton Hotel, San Antonio, Texas on January 17-19, 1958. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Texas.

Utah
The Utah State Board of Chiropody Examiners. **Board Secretary:** Dr. A. Bowden, First Security Bank Bldg., Provo, Utah.

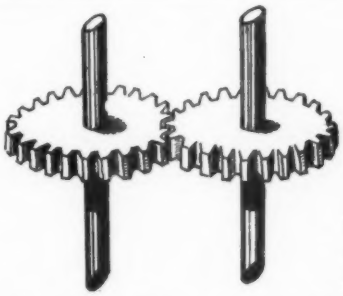
Vermont
Vermont Chiropody Association. **Board Secretary:** Dr. Regis P. Nolin, 14 Clarke St., Burlington, Vt.

Washington
The Washington State Board of Chiropody. **Board Secretary:** Edw. C. Dohm, Gen. Adm. Bldg., Olympia, Wash.

West Virginia
Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., State Office Building, Charleston, W. Va.

Wisconsin
The Wisconsin Board of Examiners. **Board Secretary:** Dr. O. J. Trimborn, 208 E. Wisconsin Ave., Milwaukee 2, Wis.

Wyoming
The Wyoming State Board of Registration in Chiropody. **Board Secretary:** Dr. Duane NeuSchultz, 2201 West A, Torrington, Wyo.



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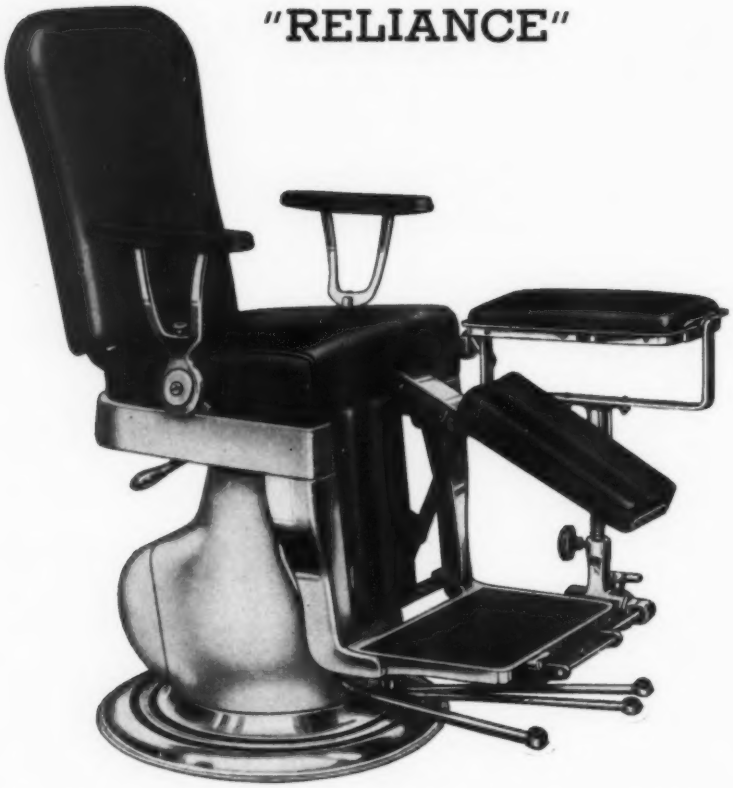

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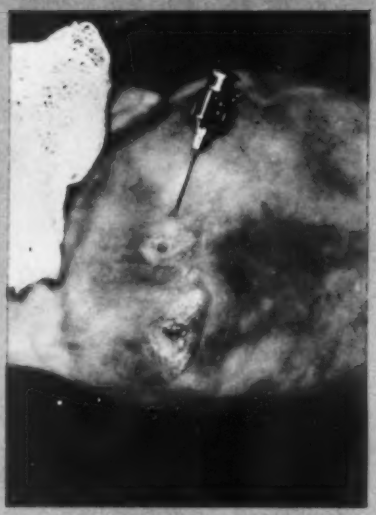
CORTICOSTEROID INJECTION THERAPY IN THE FOOT

RAYMOND K. LOCKE, D.S.C., F.A.S.C.R.

Hackensack Hospital, Hackensack, New Jersey

TECHNIQUE FOR PREDNISOLONE ACETATE INJECTION THERAPY OF NEUROFIBROUS HELOMA



TECHNIQUE FOR INFILTRATION OF ANESTHETIC

TECHNIQUE FOR INJECTION OF STEROID DIRECTLY INTO THE LESION

Procedure: Cleanse injection area with alcohol sponge and antiseptic.

Minimize initial injection pain with ethyl chloride spray.

Using tuberculin syringe and #25 needle, inject intradermally and subdermally 1 cc. of procaine *very slowly*.

Slowly inject and disperse desired amount of prednisolone acetate into under the lesion. Withdraw needle quickly, blot puncture area, and app a sterile dressing.

Dosage: Averages 5 mg.

NEUROFIBROUS HELOMA

COMPLETE REGRESSION AFTER
CORTICOSTEROID INJECTION THERAPY

RESULTS OF INJECTION THERAPY WITH PREDNISOLONE ACETATE FOR NEUROFIBROUS HELOMA

	Number of Patients	Average Duration of Lesions	Previous Therapy
EXCELLENT IMPROVEMENT	19	14.1 years	x-ray, radium, liquid nitrogen, carbon dioxide snow, potential cautery, surgery, electro-surgery and various orthopedic measures
GOOD IMPROVEMENT	4	11.5 years	
FAIR IMPROVEMENT	3	15.0 years	
NO IMPROVEMENT*	3	10.0 years	

*Failure due in part to lack of cooperation by patients in following supportive measures.

TECHNIQUE FOR PREDNISOLONE ACETATE INJECTION THERAPY OF HELOMA DURUM AND MOLLE

HELOMA DURUM — TECHNIQUE FOR INFILTRATION OF ANESTHETIC AND INJECTION OF STEROID

Procedure: Cleanse injection area with alcohol sponge an antiseptic.

Minimize initial injection pain with ethyl chlorid spray.

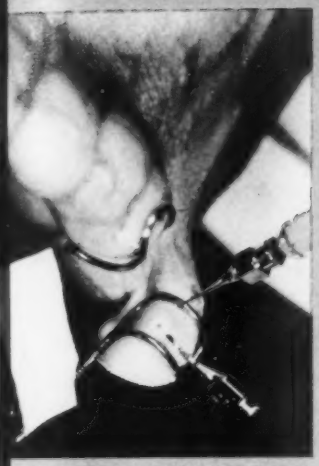
Using a tuberculin type 1 cc. syringe, infiltrate injection area slowly with 1 cc. of procaine. Inject desired amount of steroid intradermally or into bursal sac. In case of capsular or articular involvement, follow technique for intra-articular injection.

Withdraw needle quickly, blot puncture area, a apply a sterile dressing.

Dosage: Averages 2 to 5 mg.

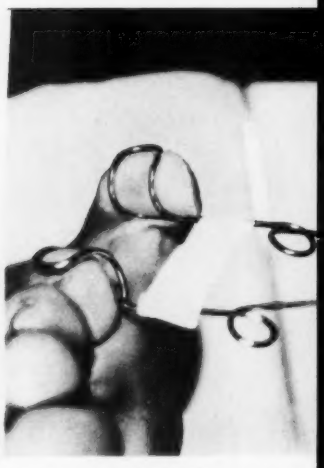
HELOMA DURUM IN PATIENT WITH RHEUMATOID ARTHRITIS

COMPLETE REGRESSION AND AB OF EDEMA AFTER ONE INJECTIO CORTICOSTEROID



ELOMA MOLLE—TECHNIQUE FOR INFILTRATION OF ANESTHETIC AND SUBDERMAL INJECTION OF STEROID

HELOMA MOLLE RESISTANT TO CONVENTIONAL THERAPY



COMPLETE REGRESSION AFTER ONE INJECTION OF CORTICOSTEROID

RESULTS OF CORTICOSTEROID THERAPY FOR HELOMA DURUM AND HELOMA MOLLE

	Number of Patients	Heloma Durum (Number)	Heloma Molle (Number)	Avg. Number of Injections
COMPLETE REGRESSION	31	28	7	1.3
MAJOR IMPROVEMENT*	26	29	3	1.3
GOOD IMPROVEMENT**	15	16	3	1.3
FAIR IMPROVEMENT†	21	23	1	1.5
NO IMPROVEMENT††	12	11	7	1.6

*Heloma recurred but markedly diminished in size with much longer relief of pain.

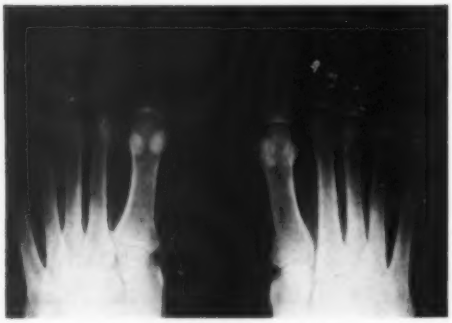
**Good relief of pain and longer freedom from regrowth of excrescence than with conventional therapy.

†Fair relief, slightly better than with previous therapy.

††No relief or, if any, no better than with ordinary palliative measures. Six patients in this group required surgery.

COMMON DISORDERS AMENA

OSTEOARTHRITIS OF TALONAVICULAR AND ANKLE JOINTS



RHEUMATOID ARTHRITIS

TENDINITIS AND CALCANEAL SPURS

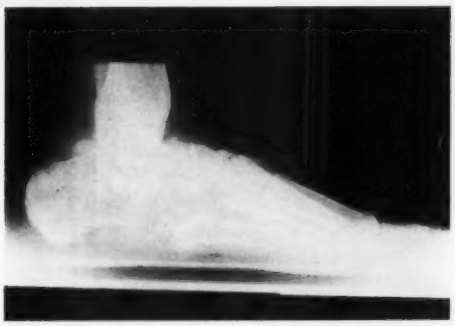
HALLUX RIGIDUS

EDEMA OF TOE ASSOCIATED WITH SECOND M. P. JOINT DISTURBANCE

CORTICOSTEROID THERAPY

GOUT OF FIRST M. P. JOINT

SEVERE DISLOCATION
OF SECOND M. P. JOINT



TRAUMATIC ARTHRITIS OF SUBTALAR AND
TALONAVICULAR ARTICULATIONS

POSTSURGICAL (HALLUX VALGUS OPERATION)
TRAUMATIC PERIARTHRITIS WITH SECOND
M. P. JOINT CHANGES DUE
TO DISTURBED MECHANICS

TECHNIQUES FOR PREDNISOLONE ACETATE INJECTIO HER

INTRA-ARTICULAR

Procedure:

Employing aseptic precautions, anesthetize injection area by infiltration.

Insert needle (23-22 gauge, 1"-2" length, according to injection area) into synovial space, aspirating synovial fluid into syringe whenever possible. Without withdrawing needle, attach second syringe with desired amount of steroid and inject into synovial space.

Withdraw needle quickly, blot puncture area, and apply a sterile dressing.

Dosage:

Ankle and tarsal articulations—averages 12.5 to 25 mg.

Metatarsal-phalangeal articulations—averages 5 to 10 mg.

Interphalangeal articulations—averages 2 to 5 mg.

INTRABURSAL

Procedure:

Employing aseptic precautions, anesthetize injection area by infiltration.

Insert needle into bursal sac and aspirate excess bursal fluid into syringe.

Without withdrawing needle, attach second syringe with desired amount of steroid and instill into bursal sac.

Withdraw needle quickly, blot puncture area, and apply a sterile dressing.

Dosage:

Averages 5 to 15 mg.

CALCANEAL SPURS

Procedure:

Employing aseptic precautions, anesthetize injection area by infiltration. (Post-tibial block is of great value in this procedure.) Without withdrawing needle, attach second syringe with desired amount of steroid and infiltrate area about ⅛" to ¼" from the involved area of the bone.

Withdraw needle quickly, blot puncture area, and apply a sterile dressing.

Dosage:

Averages 25 mg.

PERIARTICULAR

Procedure:

Employing aseptic precautions, anesthetize injection area by infiltration.

Inject steroid into periarticular tissues by infiltration.

Withdraw needle quickly, blot puncture area, and apply a sterile dressing.

Dosage:

Follow dosage ranges for intra-articular injection. Since infiltration technique is employed, dosage may be slightly higher for periarticular injection.

GANGLION

Procedure:

Employing aseptic precautions, anesthetize injection area by infiltration.

Using a large needle (16-18 gauge) and a 10 cc. syringe, aspirate fluid from ganglion into syringe. Without withdrawing needle, attach second syringe with desired amount of steroid and inject directly into the ganglion.

Withdraw needle quickly and blot puncture area.

Note: It is of value to apply a compression bandage immediately following injection.

Dosage:

Averages 10 to 15 mg.

Important:

Injection procedures must be conducted under rigid aseptic conditions. Syringes, needles and other equipment employed in these techniques should be autoclaved. Preparation of the patient should consist of a four-minute scrub of the injection area with hexachlorophene or other suitable detergent and application of an antiseptic solution. Following skin sterilization, area should be immediately covered with a sterile dressing until ready for injection.

PRECAUTIONS:

Under no circumstances should an injection be made in an area where infection is present or suspected in or near the selected joint.

RESULTS OF INTRA-ARTICULAR INJECTION OF PREDNISOLONE ACETATE FOR ARTHRITIDES AND ALLIED DISORDERS

	No. of Cases	Avg. Injection Per Patient	Avg. Duration of Improvement (months)	Degree of Improvement — No. of Patients				
				0+	1+	2+	3+	4+
Osteoarthritis	42	1.5	11.17 (2-21)	2*	1	4	9	26
Traumatic Arthritis	19	1.26	11.53 (2-22)	—	—	—	5	14
Periarthritis (Capsulitis)	32	1.37	11.81 (3-21)	—	1	1	4	26
Rheumatoid Arthritis	6	1.83	10.17 (7-13)	—	—	4	—	2
Gouty Arthritis	4	2.0	12.0 (6-20)	—	—	—	—	4
Luxations & Subluxations	36	1.39	15.69 (6-22)	—	—	2	5	29
Hallux Valgus	16	1.66	12.57 (3-21)	—	3**	2	—	11
Calcaneal Spurs	7	2.0	15.71 (10-19)	—	—	1*	—	6
Other Conditions***	16	1.37	16.66 (7-22)	4	—	2	6	4
TOTAL	178			6	5	16	29	122

*Patients Uncooperative

**Patients Required Surgery

***Sesamoiditis, Morton's Neuralgia, Ganglion, Tailor's Bunion, etc.

0+ — No relief (relief, if any, no greater than with previous measures).

1+ — Partial relief (fair) or of short duration. Slight decrease in swelling and pain.

2+ — Good relief of pain and longer remission. Definite reduction in swelling and pain and improved function.

3+ — Major improvement in which relief of symptoms is complete with greatly reduced swelling and tenderness.

4+ — Complete remission. No recurrence of pain, limitation of function, tenderness or swelling of the part.

SUMMARY

- Deformities, such as hammer toe, contracted toes, tailor's bunion, and even symptomatic hallux valgus, heretofore considered largely of pathomechanical origin, often appear to be symptoms of capsulitis, osteoarthritis, periarthritis and other degenerative joint disturbances.

- Trauma of a subclinical nature, producing prolonged inflammatory reaction in the articular and periarticular tissues, may be a major factor in the etiology of degenerative joint disease in the foot.

- The second M. P. articulation is the joint of the foot most often affected. Periarthritic and arthritic involvements of the second M.P. joint usually accompany hallux valgus either in the incipient or well-developed stages.

- Response to therapy directed toward the alleviation of the secondary conditions – hammer toe, corn, or callus – is often unsatisfactory since the primary conditions of degenerative joint disease – traumatic arthritis and/or periarthritis – are left relatively untreated.

- The combined use of the anti-inflammatory corticosteroids such as prednisolone acetate with the various mechanical orthopedic and chiropodal supportive measures has produced longer periods of remission and better clinical results than those obtained with either therapeutic measure alone.

- Supportive measures – balance and shoe therapy, static or dynamic molds – enhance the efficacy of local corticosteroid injection therapy by assuring better mechanical function.

METICORTELONE® ACETATE USED IN THIS INVESTIGATION WAS SUPPLIED BY SCHERING CORPORATION.

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JOURNAL

OF THE

AMERICAN PODIATRY ASSOCIATION

THE OFFICIAL PUBLICATION OF THE PODIATRY-CHIROPODY PROFESSION

VOLUME 48 JANUARY, 1958 NUMBER 1

KEEPING FRACTURE CASES AMBULATORY*

The Use of Celastic and Cohesive Gauze for the Ambulatory Casting of Fractures of the Foot

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The treatment of foot and toe fractures, as described in the medical literature, varies from the extremes of inexperienced indifference to the impractical.

Lewin[1] censures the former that fractures of the foot "should be given as careful attention as accorded fractures of the hand." Especially is that true for those who actually ignore a toe fracture or advocate that "it be simply bandaged to the next toe as a splint."

For the other extreme, Charnley[2] comments, "A popular impulse to apply plaster of paris to practically anything in which the x-ray shows a fracture would seem to spring from an unvoiced belief that plaster of paris is some sort of dressing which, when applied to the skin, accelerates the healing of the underlying bone."

For the past ten years, your author has successfully used celastic splints with cohesive gauze on nearly 350 fracture cases of the foot and toes. Pain-free weight-bearing was accomplished immediately, obviating any loss of work; and the patient wore his own unmutilated shoe, almost without exception. The procedure is simple and quick.

Although injuries do occur to the foot in which the crushing effects produce severe bone deformities that require open surgical intervention, the most common foot fractures are not so involved.

In the most usual fractures, if displacements or deformities are necessary to be reduced, it can be done simply after a local anesthetic is injected into the fracture site. The use of hyaluronidase, added to the anesthetic, will facilitate the reduction, especially if the fracture is not a fresh one.

It is a fairly common observation that even untreated fractured bones do heal, although usually with some deformity. However, even a treated fracture may also have an abnormal sequela.

On the other hand, it is not unusual that we see a foot and leg that has been immobilized in plaster of paris for a number of weeks because of a fracture. The fracture site is well healed and symptom-free. However, there are painful joints or circulatory disturbances that were not originally involved but have developed because of the prolonged immobilization.

The application of plaster of paris does not accelerate the healing of bone. It is

* Honorable Mention Paper in the 1957 William J. Stickel Annual Awards for Research in Chiropody. Presented at N.A.C. Annual Meeting, Chicago, August 1957.

merely one way to ensure that the bone will be in good alignment when healing takes place.

Because of the movement between the skin and bones, it is impossible to achieve absolute immobilization between the fractured ends of bones with a plaster of paris cast. And it is almost "futile to expect a walking plaster of paris cast to immobilize a fracture in the tarsus or metatarsus."[2]

When an extremity is immobilized in a plaster cast, certain changes will occur as a result of the inactivity. There is a decrease in the blood supply and drainage that will result in atrophy of the muscles and contracture of the ligaments. The fibrosis following the inflammatory reaction to the trauma will cause adhesions. The part will become weak and painful. The disturbed vasomotor function results in dependency edema.

In the treatment of fractures, Bohler, an orthopedic surgeon, was the first to advocate that the limb should be actively employed in the performance of useful work while in its cast. He used skin-tight plaster of paris casts, with the joints involved in the optimum position for function.

Ferguson[3] states, "The policy of waiting until a splint or cast is removed before any activity of the part is begun is to be deprecated. In many fractures the active use of the extremity may be regained to a considerable extent—as soon as an accurately fitted unpadded cast is applied."

For the uncomplicated, minor fractures of the tarsal bones; and for the vast majority of the fractures of the metatarsals and phalanges (and it is reiterated that these are the types under discussion) the use of a plaster of paris cast is unwarranted. Beyond the inconvenience to the patient from an occupational, social, or a hygienic standpoint, the postural imbalance plus the local and remote disturbances to the locomotor system leaves the plaster cast, as a therapeutic measure for these fractures, with a great deal to be desired.

The following technic produces an immobilization superior in every respect to plaster of paris. It is truly skin-tight and waterproof. The part and its joints are in the normal function attitude and enabled to be employed in that function to the greatest possible extent. After the fracture has had time to unite, no further therapy or rehabilitation is normally necessary.

Materials

Celastic®[1] (and activator): This is a cotton fabric impregnated with a cellulose nitrate colloid. By dipping the fabric into a "softener," or activator (which is an organic solvent), the colloid is dissolved. When the solvent evaporates, there is a continuous film of cellulose nitrate. Reinforced by the cloth, the result is relatively rigid. The thickest (#125) celastic is used.

Pro-tek®[2]: This water-washable cream is a polyvinyl alcohol paste which will serve as skin barrier to protect the hands of the operator when handling the organic solvent and plastic of the celastic. While it is comparatively impervious to organic liquids, it can be simply removed by washing with soap and water.

Rubber cement: This serves a dual purpose. Painted on the skin surface of the celastic (before it is dipped into the activator) it acts as a barrier to protect the skin of the patient. Painted on the skin of the patient, it adheres the celastic and the cohesive gauze to produce a truly skin-tight cast.

Cohesive gauze ®[3]: 1½″ and 2″ for foot and ankle; 1″ and ½″ for the toes.

Preparation of Celastic

The following are the usual locations and extent of the celastic splints used. Variations are frequently indicated. The severity of the fracture and the foot type will dictate the need for a larger or smaller

®[1] ®[2] Du Pont
®[3] Gauzetex General Bandages, Inc.

celastic section. If any doubt exists, begin with the maximum.

A. Tarsal and Metatarsal Fractures

Except for digital fractures, a piece of celastic (#125) is used that is the shape of the full sock lining or insole of the shoe, with the heel seat cut longer and wider. For tarsal involvements the medial (and lateral) flanges may be included on the celastic. The edges may be skived. (Fig. 1)

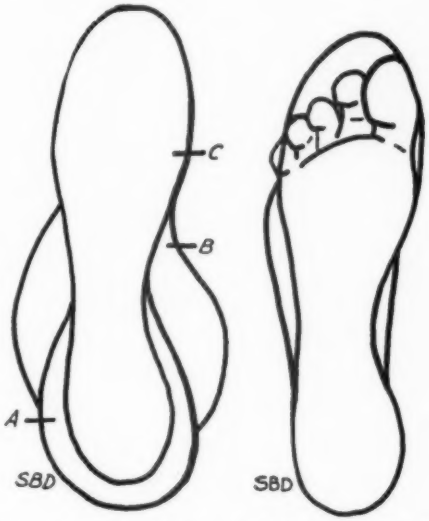

Fig. 1 (Left) A. Usual additional celastic for heel cup. B. Medial and lateral flanges. C. Area of no increase.

Fig. 2. (Right) Insole of shoe is narrower than sole of foot. This is more marked in the female.

Placing this blank against the foot, it may be found to be necessary to cut away the celastic distal to the toes, although some of the extra length will be lost since the celastic must follow the contour of the foot as opposed to generally flat shoe insole.

This dry run will be highly illuminating in another respect. That is the discrepancy between the width of the plantar surface of the foot and the width of the usual insole of the shoe. And since we must walk on the soles of our shoes, not the uppers, it is apparent that there is considerable compression of even the average foot in the average shoe. (Fig. 2)

Fig. 3. Transference of ball-pen outline marking to celastic.

Until experience has been gained, observation of the position of the M.P. joints as worn inside the shoe will indicate the placement of the celastic (insole duplicate) against the foot. If it is necessary to cut the celastic wider than the shoe insole, in order to cover an involved plantar area that is overriding onto the shoe upper, avoid increasing the width at the antero-medial shank area.[4] (Fig. 1, C)

B. Phalangeal Fractures

For digital fractures (and for those for which the entire insole pattern is not necessary), the exact shape of the celastic is determined by drawing the desired outline with an inexpensive (free-flowing) ball-point pen directly on the skin and removing a transfer with adhesive tape.[6] Then cut the outline out of the adhesive tape. Apply tape to the celastic, outline with a pencil, then cut the outline out of the celastic.

(This same invaluable technic can be applied to the shaping of pads or dressings, as an aid for yourself, or as an exact guide for your assistant. Non-adhesive materials can be shaped by the two-step process described above. The adhesive materials (moleskin, ad felt, etc.) will remove the transfer directly. This will enable you to accurately cut out any shape, no matter how intricate. It is of even greater value since it will permit the doctor to outline the dressings or paddings for H.D.s, bunion joints, balance pads, etc. very quickly. Then his assistant will be able to cut and apply the material of choice to exact size and know exactly where they are to be placed. (See illustrations))

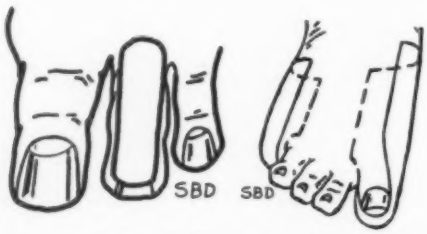

Fig. 4. (Left) Ball-pen marking for dorsum of 2nd toe.
Fig. 5. (Right) Ball-pen markings for 1st and 5th metatarsal segments.

Except for the hallux, fractures of the middle and distal phalanges of the toes can be simply immobilized. The motions and range of the lesser interphalangeal joints are usually quite restricted. Celastic applied to the entire dorsal surfaces of the involved toe will suffice. (Fig. 4)

Fractures that enter into the interphalangeal hallux joint do best when the entire 1st segment is splinted. Apply the celastic on the plantar surface, from the distal end of the toe back to include the 1st met-cuneiform joint.

Fractures of the proximal phalanges of the hallux and 5th toe. Because of the transverse stabilizing function of the medial and lateral forefoot segments, the celastic should cover the three external surfaces of the respective segments, from the tarsal joint to the end of the toe. (Fig. 5)

Proximal phalanx of the three middle toes. The celastic should extend over the plantar surface of the toe to the base of the meta; and should include at least the two adjacent metatarsals. (Fig. 6)

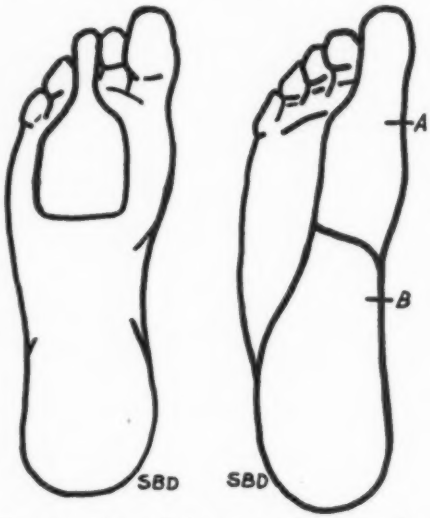

Fig. 6. (Left) Ball-pen marking for plantar surface of a toe and adjacent metatarsal area.
Fig. 7. (Right) Ball-pen marking for sesamoid involvement.

Sesamoids. Celastic should cover the plantar aspect of the hallux and the first and second metatarsals. Sometimes the celastic should be continued back to include the heel and thus hold the entire length of the Flexor Hallucis Brevis inactive. (Fig. 7, A and B)

The skin surface of the celastic is covered thoroughly with rubber cement, dried and placed into the activator. It should remain until bubbling ceases, drained and is ready to be applied. After removal from the activator there is a period of thirty minutes before the initial set begins to occur. So there need be no haste. The celastic is applied before the gauze.

Preparation of the Skin

The skin area to be cast is cleansed with an organic solvent and alcohol, then painted with tincture of benzoin compound, followed by two coats of rubber cement. The rubber cement bottle and brush used here (and to apply cement to the celastic) should not be used for any other purpose. Especially in comparison to the relatively high incidence of the exacerbations of existing or latent phytotic infections that occur under adhesive tape therapies, we have never encountered that problem during celastic-cohesive gauze treatment of fractures.

It is not only desirable, but necessary that the patient apply his shoe and be ambulatory before the celastic hardens. The shoe is to remain on until the celastic hardens (2-6 hours). At that time, a sometimes annoying, but innocuous burning may be noticed.

Except for certain toe fractures, the patient is cautioned not to take a step without the shoe on. Thus it becomes obvious, especially in the case of tarsal or metatarsal fractures, that the choice of shoe should be judicious.

The Shoe

Except for the more severe fractures that may occur in a heavy patient, or in one whose occupation is arduous and may demand heavy lifting, only one thickness of celastic is needed. Two or three thicknesses of cohesive gauze are used. The entire dressing may then be covered with tubular gauze. With the realization that the celastic will compress considerably (which increases its strength), the entire thickness of the cast is not great. In male patients, there is seldom any difficulty in using any shoe that has been worn. Some women's shoes may have to be stretched across the throat. A short shoe presents the only impossibility. Pump type shoes may be unusable, although they have been adequate in many toe fractures and even in one case of a sesamoid fracture.

It is important to understand that we rely upon the shoe for its added splinting effect. It should have a snug, even a tight fit. And if there is any question about the rigidity of the shoe shank, a fay bar or other device is used to prevent the shoe from sagging.

In cases where unusual foot types or injuries are under consideration, specific modifications of the shoe (or cast) are necessary. For example, the heavy patient with a cavus foot will need some "filler" between the mid-foot and the shoe shank. Where the trauma has resulted in a hyperextension foot injury, a lowering of the heel (or even its entire removal) may be indicated. In fractures of the tuberosities of the base of the 5th metatarsal bone, to reduce the normal pull of the Peroneal tendon during gait, the foot should be held at a right angle to the leg and slightly everted by the cast and/or shoe modifications. As in other cases where muscle spasm may be present, the use of a local anesthetic at the fracture site will relax the reflex Peroneal muscle spasm.

Cohesive Gauze

The gauze is preceded by the use of cement, which can also be applied between layers to assure adhesion and thus immobilization.

A strip of ordinary adhesive tape, which is subsequently not covered with rubber cement can be applied, along a suitable line, and away from the fracture site before the gauze. This will serve as a guide and skin protector for the bandage scissors when the cast is removed.

A piece of very thin rubber or plastic foam, or a couple thicknesses of webril should be applied to the anterior ankle area, to prevent cutting in of the gauze, in the cases where a full insole celastic is used and the ankle is covered with cohesive

gauze. Because the bandage will irritate only if it is loose and rubs, be certain to apply cement to the back and sides of the ankle.

There is no need for the celastic to cover a dorsal fracture site, as long as the bone is adequately immobilized by the use of celastic plantarly and cohesive gauze on its other surfaces.

Recalling the compression that the foot must undergo even in a well-fitted shoe, the cohesive gauze must be applied very snugly. With a little care, annoying skin wrinkles and tight bands can be avoided. To prevent pinching the skin at the edge of the celastic, a short piece of gauze can be cut and, starting at the center of the celastic, applied with tension in both directions. (In the manner of applying of a plantar "rest strap" tape.) This same application can be used over prominent areas such as the 1st and 5th M.P. joints. Then mold in the slack sections with your hand.

The wider rolls of cohesive gauze are used about the foot and ankle, the narrower about the toes. The first layer can be applied in short pieces, then applied from the roll of gauze with continuous, very firm tension. If necessary, cross-plantar pieces of adhesive tape can be used for greater tension. This is particularly true in the heel area.

When applying the cohesive gauze about the foot, it is best to go in the direction of external rotation of the foot. That is, from lateral to medial across the dorsum, and from medial to lateral, plantarly.

In order to avoid constricting bands of gauze about an individual toe, the gauze should be applied mostly in 1½-2 inch pieces. Begin with several A-P recurrent pieces. Previous application of rubber cement to the outer surface of the celastic is helpful. Then the circular pieces can be applied and molded to the toe.

In those cases, especially the 5th toe where it may be difficult to separate the involved toe from the next without risking movement at the fracture site, in order to apply the gauze about the toe, include the next toe in the circular turns of gauze. A piece of webril may be gently pulled between the toes, before casting, with the aid of a forceps.

In cases of dorsal foot fractures, and where localized edema may be present, a piece of foam, applied before the gauze, will be beneficial. That is not necessary on the toes.

When the full insole of celastic is used, the five toes are handled as though they were one. The gauze is applied, with tension, up to the bases of the toes, then all the toes are enclosed together, as described above for the individual toes, except that wide cohesive gauze is used.

In cases where the trauma has caused lacerations and/or the fracture is compound, appropriate antiseptic, antibiotic, and anti-toxin therapy should be instituted.

The neuromuscular stimulation of crest therapy is of direct and exemplary value in fracture therapy. Whenever possible, a shaped piece of wool felt is placed under the toes.[5] Depending upon the lesion, this is applied before the celastic, or separately.

The casts have proven to be effective as long as they are tight. The beneficial results of adequate immobilization, plus the active use of the part, quickly resolve the early swelling. Thus the first cast should be changed in 2-5 days. Observation of the effectiveness and the molded celastic impression will enable the doctor to decide on a reduction (or increase) in the size and extent of the celastic and the cast. A fresh piece of celastic can be cut from the outline of the old piece including modifications.

After that, the cast can remain undisturbed for much longer periods. We change the casts at one to two week intervals, using histamine or Mecholyl®[4] iontophoresis to

®[4] Merck Sharp & Dohme

stimulate repair. After a minimum two week period, muscle tone and co-ordination (which is impaired to a greater or lesser degree by this or any other restrictive, abnormal, or unilateral device or bandage) is aided by the use of Horwitz' Variometer on the appropriate muscle groups. Clinical observation of the progress is made, and x-rays are taken as necessary.

Although acrylics and other types of plastics were considered, and some even tried, experience proved that celastic was the simplest, most practical and convenient for fracture therapy.

Discussion

The effectiveness of this immobilization can be quite dramatic. The deep pain reflex (which we have found to be so consistent that we consider it to be pathognomonic for a fracture in differentiation from a sprain or contusion), that will cause the patient to be nauseous will disappear immediately, along with other noxious sensation, as soon as patient steps on his foot and begins to walk. This, of course, can only be demonstrated in those cases where prior injection of a local anesthetic was not necessary for reduction.

With fractured bones adequately fixed, the physiologic status of the extremity will be abetted if the part is active. Post-traumatic vasomotor disturbances subside rapidly and circulation is positively stimulated to hasten bone repair. Reduction of inflammatory exudates (that may form fibrous tissue to produce adhesions) is also a desired result.

In three to six weeks repair (or resolution) will have been accomplished. The patient can "step right out of his cast" without treatment often necessary for developed complications, when plaster is used.

In certain specific sites, resolution, rather than repair, will occur. And it has proven to be absolutely compatible with normal, symptomless function. For example, a fracture of a sesamoid, or of the posterior process of the talus does not unite, as a rule, except by fibrous union. And it has never been necessary for surgical removal of these fragments, although the converse was found to be true when other types of fracture management were used.

Although there is no better method of obtaining immobilization (except for internal fixation) some motion is possible, especially before the celastic sets. As a general rule, this can be used to great advantage. Some bony displacements can and must be set manually. Other displacements, which cannot be reduced by external manipulation, are not practical for open surgical reduction. One of the most satisfactory results of this technic is the improved alignment of the fractured bone ends, in this latter group, that will occur during the dynamic molding of the celastic.

Of course, the severe restrictive effects of the cohesive gauze does produce a "controlled" molding. Nevertheless, resolution of incidental symptoms of mechanical malfunction will be observed. This is a secondary, but desirable effect.

Helomata on affected toes will subside, even though they are not at the fractured site. Engel described a similar result in his work on toe shields, where the celastic was applied for H.D., not fracture therapy.

In the cases for which we used a full insole pattern of celastic, disappearance of metatarsal callous was observed, plus the improvement of orthopedic foot conditions that were remote from the fracture sites. These observations gave us the first inkling of the potential value of dynamic molding therapies many years ago.

Although other methods and materials have proven more successful for H.D. therapy, we still use modifications of this celastic technic for certain dynamic therapies.

Summary

1. A technic for the management of foot fractures is presented that minimizes post-fracture complications and simplifies convalescence.

2. The use of a plastic splint with cohesive bandages is described.

3. This technic will enable the patient to remain almost normally ambulatory during the time of bone repair.

4. Other therapeutic advantages are described.

5. As a logical extension of the observations, it was found that this technic (and other rigid plastic materials) could be successfully used for management of acute traumatic lesions other than fractures. They include contusions, osteochondritities, metatarsal and calcaneal bursitis, etc.

6. This technic was also the basis for orthodigital and other biomechanical foot devices, some of which have been discussed in earlier reports.

Conclusion

The ultimate substantiation of the effectiveness of this therapy has been somewhat left-handed. Incredulous insurance company representatives with raised eyebrows could not believe the diagnosis of fracture, when the report did not also include a lengthy disability time and a plaster of paris cast.

27 *North Brown Street*

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A SUGGESTED STANDARD SURGICAL SCHEDULE FOR OPERATIVE PROCEDURES OF THE FOOT

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Long Beach, Calif.

Insurance coverage of chiropody for the performance of foot surgical procedures has grown at a rapid rate and will continue to do so. More than eighty million persons have surgical expense protection that includes foot surgery as a part of their health insurance programs.

Generally, the policy under which this insurance is provided contains a schedule setting forth the most frequent foot surgery procedures, and specifying the dollar amount of benefit with respect to each. For foot surgery not listed in the schedule, the benefit usually paid is the sum that is consistent with the amounts paid for the listed operations.

The rapid spread of this protection has resulted in the development of a number of different surgical schedules. Some designed by insurance companies and others by doctor's association. The lack of standardization in the classification of the surgical procedures and in the terminology with which they are described has been a hindrance to a more complete understanding of this important health protection by both the persons insured and the chiropodist, to whom the benefits are ultimately paid.

This paper is not directed in any way toward the establishment of either the fees for surgical benefits payable or the fees chi-

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ropodists charge for foot surgery. Furthermore it is not intended to suggest that surgical schedules will necessarily cover all procedures listed, particularly in the case of the substitute foot surgical procedures which are performed in lieu of cutting operations.

The day-to-day sale of health insurance with the inclusion of chiropody has been on the increase the past months, and will continue to increase. The current chiropody nomenclature which is not listed in the diagnostic nomenclature, the American standard nomenclature, and the international nomenclature, will have to conform with the American medical terminology accepted and listed. Bearing this in mind I have attempted to include every foot surgery which is clinically recognizable and to avoid repetition and overlapping. This paper covers over five hundred foot surgery procedures using only standard accepted terminology of Basle Nomina Anatomic; Standard Nomenclature of Diseases and Operations, American Medical Association; American Dental Association; American Hospital Association; Public Health Methods; Public Health Service.

The continued sale of day-to-day operations of surgical expense insurance requires a nomenclature which lends itself to ready understanding by lay persons responsible for the administration of the plans.

Important in handling insurance claim procedures is the continuance of the relatively simple and prompt claims settlement procedure that prevails. In order that the task of the doctor be as simple as possible and in order that the time required of the foot surgeon or his secretary to complete the claim form be kept to a minimum, the claim form calls for only a brief description of the nature of the surgical procedure.

Settlement of insurance claims are made by lay personnel, who although trained in the administration of surgical expense insurance, do not have the background and knowledge of a chiropodist. This classification and nomenclature of the surgical procedures is designed to facilitate this type of claims administration.

The author would like to acknowledge information obtained from the following or their publications: American Medical Association, Chicago, Ill., Public Health Service, Washington, D. C., American Life Convention, Chicago, Ill., American Mutual Alliance, Chicago, Ill., Association of Casualty and Surety Companies, N. Y., Association of Life Insurance Medical Directors, Newark, N. J., Health Insurance Association of America, Chicago, Ill., International Claim Association, Kansas City, Mo., Life Insurance Association of America, N. Y., Life Insurers Conference, Richmond, Va.

General Surgery (Foot)

Biopsy

- Not in the course of another operation
  - Removal of fluid or tissue for examination
  - Bone or bone marrow

Infections and Injuries

- Localized Burns
  - First degree
  - Second degree
  - Third degree
- Other Infections and Injuries
  - Accidental laceration of skin structure, suture or repair of
- Cellulitis
  - Incision or drainage for operation for inflammation of tissue
- Foreign Body
  - Removal of
    - Superficial
    - Deep
- Plastic Surgery
  - Scar tissue or keloid, excision or removal of scar tissue
- Skin Grafting
  - Direct flap or transplant
  - Pinch graft
  - Tube graft

Syndactylism
Webbing of the toes with bone involvement
Separation of webbed toes
Symphalangism–Symphalangia
Ankylosis of the proximal phalangeal joints of the toes
End to end fusion repair of
Zygodactyly
Simple webbing of the skin of the toes with normal bone alignment
Separation of webbing
Talipes
Correction of clubfoot
By manipulation and cast
By closed operation and cast
By open operation

Tumors and/or Cysts

Removal by surgical procedure
Benign
Superficial
Warts, Clavus, Calluses
Single procedure
Multiple procedure
Deep
Single procedure
Multiple procedure
Malignant
Specify
Single procedure
Multiple procedure

Musculoskeletal System (Foot)

Amputations

Toe (one or more phalanges) amputation of
Single
Multiple
Foot, amputation of; below the ankle
Bones, plates, pins, removal of
Diseased portion of bone, removal of
not for osteomyelitis
not for inflammation of bone marrow
Exostosis, removal of
Removal of bone spur
Single
Multiple
Hallux Valgus, operation of bunion
Simple
Radical, complete removal
Hallux Rigidus, joint arthroplasty
Simple
Radical
Lengthening or shortening of bone
Osteotomy
Metatarsal bone, removal of bone of foot
One
Multiple
Digitus Pedis Malleus, surgical repair of
Single
Multiple
Onychocryptosis, removal of nail bed, fold, matrix
Partial
Complete
Onychochauxis
Partial
Complete
Onychocryptosis
Partial
Complete
Phalanx
Removal of bone of toe
One
More than one
Sesamoid Bone
Removal of bone developed in tendon
Tarsal Bone
Removal of
One
More than one
Osteomyelitis
Bone abscess
Operation for
Sequestrectomy
Removal of dead bone fragment

Bursae

Aspiration. One or more, removal of fluid by needle
Bursectomy, excision of, removal of sac
Bursotomy, cutting operation of sac
Irrigation of bursae, washing of bursae sac
Injection. One or more

Dislocations

Closed reduction is correction of displacement by manipulation without incision
Open reduction is correction of displacement by incision
Astragalo-tarsal bones, dislocation of
  Closed reduction
  Open reduction
Metatarsal bones, dislocation of
  Closed reduction
  Open reduction
Tarsal bones, dislocation of
  Closed reduction
  Open reduction
Toes, dislocation of
  Closed reduction
  Open reduction

Fractures

Astragalus

Simple	Compound
Closed	Closed
Open	Open

Metatarsal Bone

Simple	Compound
Closed	Closed
Open	Open

Os Calcis

Simple	Compound
Closed	Closed
Open	Open

Tarsal Bones

Simple	Compound
Closed	Closed
Open	Open

Toes

Simple	Compound
Closed	Closed
Open	Open

Joints

Arthrodesis or arthrectomy (operative ankylosis)
  Excision or surgical fixation by fusion of joint surfaces, with or without tendon transplant
Arthroplasty
  Reconstruction, functional restoration or other plastic surgery on joints
Arthrotomy
  Cutting into joint
Capsuloplasty
  Plastic repair or joint capsule
Capsulotomy, Capsulorrhaphy, or Synovectomy
  Cutting into or removal of synovial membrane
Arthrocentesis
  Tapping of joint
  Surgical puncture of joint
Manipulation of fused or frozen joint
  Under local anesthesia
  Under general anesthesia

Muscles

Myotomy . . . Division of Muscle
  Repair or suture of muscle
    Single
    Multiple
  Severance of Muscle
    Complete
    Partial
  Transplantation of Muscle
    Single
    Multiple

Tendons

Tendon sheaths, fascia and ligaments
  Excision of ganglion
  Excision of cyst
  Excision of abscess
  Excision of other lesions of tendon or sheath
Fasciectomy
  Dupuytren's contracture
    Cutting away of fascial tissue
Graft
  Tendon, free
  Fascial, free
Lengthening or shortening of tendon
Suture of tendon
Tenotomy
  Cutting of tendon
Transplantation of tendon
  Advancement
  Recession

Arteries and Veins

Aneurysm, arterial or arteriovenous, operation for or repair of diseased blood vessels of the foot

Angiography or arteriography, examination of artery by x-ray

Arterial anastomosis
Joining or forming a connection between two arteries

Arteriorrhaphy
Suture of artery

Arteriotomy or embolectomy
Exploration or removal of embolus
Removal of plug or clot blocking artery of foot

Ligation, other than varicosity
Tying of vein

Ligation, primary surgical
Tying of artery

Phleborrhaphy of deep vein
Suture of deep vein

Veins

Varicose Ulcer
Excision of, including skin graft

Venesection or Phlebotomy
Cutting into vein for purpose of bleeding

Venous Anastomosis
Forming a connection between two veins

Trephination
Burr or drill holes

Nerves

Nerve block operation
Injection of nerve or ganglion
Diagnostic
Therapeutic

Neuroma, extirpation of
Cutting away of nerve growth

Neurolysis
Repair or freeing of adhesions of nerve

Transplantation of nerve

1084 Atlantic Avenue

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Comment

Dr. Amberry is to be commended for a sincere effort to bring before the profession the necessity for standardization of operative terminology and for a very excellent job of compiling his material.

In reviewing his paper it is evident that his is an attempt to set up a standardized surgical schedule on operative procedures of the foot that would conform to similar surgical schedules which are referable to other areas of the body.

It may be of interest to mention here that the Nomenclature Committees of the American College of Foot Orthopedists and of the American Podiatry Association (formerly N.A.C.) are now working with the editors of the Standard Nomenclature of Diseases and Operations of the A.M.A. in an endeavor to have terms acceptable listed in the fifth edition (1960) of the Standard Nomenclature of Diseases and Operations.

The operative procedures as now listed in the S.N.D.O. may be used with any system of the body where they are applicable.

Peter N. Varzos, D.S.C.
Chairman, Nomenclature
Committee, A.P.A.

FOOT ORTHOPEDICS IN THE AGED*

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Hasbrouck Heights, N. J.

Introduction

I. The geriatric foot through the process of aging has lost its ability to alter its form or structure. Therefore, it will no longer readily respond Wolf's or Davis' law.
   A. Treatment must be aimed at increasing the functional ability of that foot without attempting to change its architecture.
      1. A conservative approach is of the utmost importance.
         a. Conservative treatment is not palliation but is that treatment which will increase the patient's ability to function without attempting to correct his structural disabilities.
      2. The basic underlying problems must be taken into consideration.
         (1) Arthritides
         (2) Peripheral Vascular Diseases
         (3) Metabolic Diseases
         (4) Other Debilitating Diseases
      a. Adjunct treatment
         (1) Systemically administered
            (a) Vitamin therapy, particularly of the "B" Complex group.
            (b) Salicylates
            (c) Cortico-Steroids
         (2) Local injection of
            (a) Anesthetic solutions
            (b) Cortico-Steroids

      note: the patient's general health must be thoroughly considered when using these injectables.

*Presented at N.A.C. Annual Meeting, Aug., 1957

Treatment

I. The mechanical problem is of a static non-correctable nature.
   A. The patient needs relief of his subjective symptoms.
      1. This relief of symptoms can be accomplished by
         a. Reducing the strain and trauma on the basic structures.
         b. Increasing the patient's ability to function with the static problem.

II. The one basic problem that is common to all geriatric patients is the loss of plantar fatty padding.
   A. Due to a general absorption of the fat.
   B. Due to a localized increase in pressure forcing fatty padding away from the areas of maximum pressure where it is most needed.
   C. Treatment can be accomplished by a multiplicity of methods.
      1. A reasonable diagnostic ability and a cognizance of the underlying problems will enable the chiropodist to treat the patient within the scope of his own armamentarium.

         note: Extreme caution must be exercised to avoid overtreatment.

III. Implements of treatment
   A. Balanced appliances
      1. The cupping effect compresses the foot, thereby forcing the normal body fat back into its natural position.
      2. This appliance *must* be made over a cast.

         note: a. There cannot be any unnatural elevation of any of the

integral bony structures, as this will cause undue pressure.

b. If properly made by a reputable laboratory, no difficulty will be encountered.

B. Molds

1. The basic effect is to spread pressure over a large area.
   a. Useful where there are small areas of extreme pressure.

note: 2. Extreme caution must be exercised not to create any areas of pressure.
   a. Crests and other elevations must be decreased and kept to a minimum.

3. Additional pads may be added to the mold to compensate for various specific problems.
   a. Metatarsal pads
      (1) The incorporation of a metatarsal with a long skive as described under Pads has a desirable effect in most cases, especially those with forefoot complaints and arthritis of the metatarso-phalangeal articulations.
   b. Other accommodative pads for specific problems.
      (1) Dancer's Pads
      (2) Reverse Dancer's pad
      (3) Double Dancer's pad
      (4) "U" Pad

C. Pads

1. Extension metatarsal pad.
   a. This is probably the most important pad used in the treatment of the geriatric.
   b. For use with the geriatric, the highest portion of the pad should come just behind the lesser metatarsal heads in a straight line and angle posteriorward behind the first metatarsal head and its sesamoids. The area of highest elevation should be from one-fourth to three-fourths inches wide and the anterior skive should extend forward almost to the web of the toes. The pad should extend posterior, the lateral edges being at the shafts of the first and and the fifth metatarsals, to the anterior edge of the calcaneus. The pad should be evenly skived to a feather edge on all sides and have no sharp edges.
      (1) This pad acts to replace the fatty pad by cushioning and keeping metatarsal heads in a straight line.
   c. The button type pad is of no value and creates trauma.
2. Innerlongitudinal pad.
   a. Has a very limited value.
      (1) Care should be taken to avoid any unnecessary pressure on the midtarsal articulations.
3. Pads to reduce specific pressures.
   a. Heel pad
   b. "U" pad
   c. Dancer's pad
   d. Reverse Dancer's pad
   e. Double Dancer's pad
   f. Other pads designed for the specific problem at hand.

D. Strappings

1. Strappings may be used on those patients whose skin is strong and supple enough to withstand the trauma of tape, however, my experience has been that it is best to avoid the use of adhesive tape wherever possible.

E. Removable Pads
   1. Toe shields, crests, traction and other pads are of great value in specific types of problems affecting the toes.
      a. Care must be taken to avoid an excess of material between the toes or under the toe sulcus.

Conclusions

I. In no area of chiropody is it so essential to have a positive approach to therapy. However, the chiropodist must beware of two major pitfalls.
   A. Strict palliation with the result that no permanent relief can be achieved.
   B. Too radical therapy with the result that it irritates, inflames and generally aggravates the condition, thereby causing the patient to become dissatisfied and fearful of any treatment other than palliation.

II. A conservative approach to a therapy designed to gradually increase the patient's ability to function, carried forth steadfastly and with perseverance will result in an excellent prognosis.

168 Boulevard

DRUGS AND PRESCRIPTIONS SAFELY USED IN THE AGED PODIATRIC PATIENT*

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It is a well-known fact that elderly people often revert to childlike ways. Many do not know, however, that this "dotage" may cause physiological as well as mental and emotional changes. Some medicines act upon the aged as they would upon a child; therefore, it is important to know just which of these medicines should be reduced to children's dosage for elderly people.

In the administration of barbiturates or bromides to the aged, one should realize that they may already be in a state of hazy consciousness. We increase this condition by giving these. Barbiturates given to aged people who are in pain often cause mental confusion. Because of this, these drugs should be given with care and in small doses. The possible toxic effects of narcotics and sulfonamides should also be considered.

Vasodilators are wonderful drugs for the aged who are suffering with peripheral vascular disorders of the foot. Some of the more common uses of these drugs are indicated in the treatment of "night" leg cramps, diabetic gangrene ulcers, thromboangiitis obliterans, frostbite and other vascular disturbances of the feet. Caution should be used in prescribing these drugs, however. One should first get the history of the patient, general observations, and general symptoms. Discretion should be employed when giving them to patients with hyperthyroidism, paroxysmal tachycardia, and angina pectoris. Some of these drugs well known to most chiropodists are Arlidin®[1], Priscoline®[2], and Roniacol®[3]. These drugs have a tendency to increase the peripheral blood flow and temperature by dilating the peripheral blood vessels.

Thrombophlebitis is found in about fifty per cent of patients with the average age of 65. Inflamed deep veins are very tender on deep palpation of these veins and

*Presented at N.A.C. Annual Meeting, Aug., 1957
®[1] Arlington Funk
®[2] Ciba
®[3] Roche

the longitudinal arch of the foot near the heel. Also, thrombophlebitis is usually accompanied by edema of the feet. A very safe and effective treatment for this is the gelatin gauze covered with elastic pressure bandage therapy, plus Adenosine-5-Monophosphates®[4] given intramuscularly.

This same treatment and medication is very useful in the treatment of varicose ulcers. In this, the first object is to control the venous stasis and edema. This can be accomplished by applying the pressure bandage from distal ends of the metatarsal up to the tibial tuberosity. The ulcer should be dressed with Erythrocin-Neomycin Ointment®[5], covered with zinc oxide tape or Telfa®[6], and a one-fourth inch rubber pad slightly larger than the ulcer. Venous return can be promoted by walking or an exercising movement of the ankle.

Antibiotics and ataractics (the tranquilizing drugs) have been a blessing for the aged person who needs surgery. The elderly patient should not be deprived of surgical treatment on the ground of age alone. The general indication for surgery is the same, whether the patient is old or young. The surgeon should evaluate the patient's mental and physical state before using surgical treatment. It is a recognized fact that surgery in the aged does not carry an unwarranted risk if proper pre-operative care is given.

The patient's cooperation and confidence in his doctor are essential. The surgeon should outline the surgical treatment, the possibility of complications that may arise in the absence of surgery, without over-persuasion. Shock and hypotension should be avoided.

Foot surgery required on elderly people is usually of the elective type, seldom an emergency. Therefore one has time to check laboratory work, general health and allergies, and to use pre-operative medications.

Anesthesia and pre-operative medication should be minimal. Most of the surgical chiropodists prefer local anesthesia in about ninety per cent of their surgeries. The less toxic of local anesthetics should be used, and vasopressor drugs such as epinephrine should be strictly avoided. There are many good local anesthetics; my preference is Xylocaine Hydrochloride®[7], and Novocaine®[8].

1700 Exchange Blvd.

®[4] Bischoff
®[5] Abbott
®[6] Bauer and Black
®[7] Astra
®[8] Winthrop

"True glory consists in doing what deserves to be written; in writing what deserves to be read; and in so living as to make the world happier and better for our living of it."

Pliny

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

DIABETIC NEURO-ARTHROPATHY

A Case Report

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THE FOLLOWING is a case report of what the author considers a rare lesion in everyday chiropody or medical practice. Although this report may have several questions unanswered, including a positive diagnosis, it is presented as a thought provocative case with the sincere desire that some readers may have case histories of a similar nature and that, with other accumulative findings, a better understanding of this syndrome may be obtained.

Mr. E. J., a white, unmarried male, 74 years of age, presented himself at my office on 2/6/56 with the chief complaint of an infected fifth toe of the left foot which was "bad". The condition started about two months previous and had become progressively worse. He had "peeled off the toe after a good hot bath around Christmas, 1955." Following this incident, dark spots began to appear around the ankle and scales began to form over the toe involved.

The patient, an artist and cartoonist by profession, was amiable and possessed a high degree of intelligence. About five years ago it was discovered that he had diabetes mellitus, at which time he was placed on an insulin regime and a diet by his medical advisor. Shortly thereafter, he stopped taking the prescribed insulin, disregarding his physician's advice and placed himself on a "strict" diet. However, he continued to have periodic blood and urine tests done at regular intervals. His blood sugar was within normal limits as of 1/6/56 and there was no evidence of glycosuria as of 2/4/56.

Symptoms of arteriosclerotic peripheral vascular disease were noted about three years ago, the outsanding symptom being intermittent claudication. Other than the foregoing findings, the patient was apparently in a state of relatively good health.

Examination of the left fifth toe revealed a circumscribed crusted ulcerated area on the dorsum at the medio-distal articulation with underlying drainage. The discharge was sero-sanguinos. There was evidence of a moderate band-like constricture of the toe just proximal to the lesion. The toe appeared shiny, dusky and edematous with a cleft-like opening on the lateral aspect just distal to the medio-distal articulation. There was little or no pain associated with the complaint.

Marked muscular changes were noted. Major color changes were seen, intermittent claudication was noted in the history, but the local temperature in both was only slightly subnormal. Pulsations of both the dorsalis pedis and posterior tibial arteries were absent bilaterally. Oscillometric readings of the upper calf of both extremities showed an amplitude of 1.25. Neurological examination revealed reflexes to be equal and active with absence of pathological reflexes. Sensations were generally diminished, but were considered within normal limits considering the patient's age.

Examination of the right fifth toe revealed a marked band-like constricture just proximal to the head of the proximal phalanx. The patient admitted that "bathroom surgery" had been administered a tylomatous lesion of that toe. He also stated that the

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constricture was getting progressively worse. At this time there was no evidence of ulceration and/or active infection.

Fig. 1 Left—radiograph of the toe. Right—the lesion.

Roentgenological examination revealed moderate decalcification of the bones of the feet with some areas showing cortical destruction, particularly the base of the fifth metatarsal bilaterally. The left fifth toe revealed almost complete lysis of the distal phalanx except for a small part of the base and the distal left. There was some erosion noted on the head of the proximal phalanx. The right fifth toe showed marked attenuation and, on the oblique view, a complete severance of the head from the neck of the proximal phalanx. The distal phalanx appeared intact. Calcification of the inter-metatarsal and inter-digital vessels was noted more pronounced in the right foot.

The diagnosis of a diabetic ulcer with osteomyelitis of the fifth toe of the left foot was obviated by the clinical and radiological evidence. The lesion on the fifth toe of the right foot presented the possibility of both vascular and neurotrophic involvement.

The constricting nature of this lesion suggested the probability of a neurotrophic disturbance. A tentative diagnosis of "diabetic ainhum" was made. However, in discussing the treatment of this problem, the possibility of a peripheral vascular etiological factor must be considered.

Treatment at that time consisted of judicial debridement of the ulcerated fifth toe of the left foot and application of a sterile gauze dressing with neomycin-gramicidin[1] ointment. Systemic antibiotics were also administered[2]. The patient was placed on Buerger-Allen exercises and referred to an internist for a general physical evaluation and care. On subsequent visits, the patient's condition showed slight improvement. The patient reported some improvement of the symptoms of claudication. There was evidence of healing in the ulcerated area and the progession of the constricture of the fifth toe on the right foot seemed to have been aborted.

The following is his physician's report:

Mr. E. J. has known of diabetis mellitus for five years and arteriosclerotic peripheral vascular disease for three years and has recently been treated by you for a "constricting lesion" of the right fifth toe which responded to your treatment beautifully.

Mr. E. J.'s chief complaints are nocturia frequency and urgency, which although they go back a few years have

[1]Spectrocin—Squibb [2]Mysteclin—Squibb

become more prominent recently. I found Mr. E. J. to be an amiable gentleman in relatively good health. His diabetis has been intelligently controlled by diet alone and apparently his strict adherence to your therapeutic regimen for his legs has been very successful since he states that he can now walk without claudication for a rather considerable distance.

His prostate showed grade 2 enlargement, but was smooth. His heart, lungs and kidneys showed no abnormalities. The retinal vessels were attenuated on the right and there were slight diabetic exudates present. The left eye was totally blind with destruction of the retina. The extremities showed marked peripheral vascular changes with loss of subcutaneous tissue, pigmentation and absence of dorsalis pedis and anterior tibial pulsations. The oscillometer readings were ¼ unit at each calf. There were fairly good popliteal and femoral pulsations. The reflexes were equal and active. The x-ray changes in the feet were very interesting and were reported by Dr. Zuckerman as follows:

Both feet show some cortical disintegration in the proximal portions of both fifth metatarsal, a structural change in the third metatarsal-phalangeal joint on the left, and absorption of the major portion of the distal two-thirds of the terminal phalanx of the fifth toe on the left and a marked attenuation of the neck of the proximal phalanx of the fifth toe on the right. These findings are quite bizarre and suggest the possibility of a neurotrophic disturbance. There is no soft tissue swelling about the involved areas. The multiplicity of findings does not suggest ainhum. Leprosy must of course be considered, although the terminal phalanx is usually not involved. There is mild calcification of the vasculature of the feet.

DAVID H. PALEY, M.D.

Conclusions

Since treatment measures instituted were aimed primarily at increasing the arterial flow to the lower extremities and control of the infection, it is significant to the author that this therapy also appeared to have stemmed the progression of a lesion most likely neurotrophic in origin. It is apparent that definite conclusions on this subject would be completely unreliable when founded on one case history. The author would welcome reports of similar cases from readers, in order to accumulate more data on this interesting and intriguing foot problem.

134 Engle St.

DYNAMIC BALANCE THERAPY*

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THE foot is in constant conflict with the shoe in which it is housed. The "stock shoe" because of its restrictive design forces the foot into an attitude which is not conducive to its normal functioning. The leg muscles which have their insertion in the foot, therefore, are not afforded the freedom necessary for them to perform at maximal efficiency.

The blame for this limited function cannot be placed entirely upon the restricting shoe. Occupation, weight, general systemic vitality of the person and the hard surfaces upon which civilization has forced man to walk, all play a role in producing malfunction with subsequent deformity in the feet. The problem which confronts the chiropodist is: What can we do for the foot and its adjacent structures to overcome those forces which tend to produce malfunction and deformity?

A product developed by a Michigan chiropodist in 1953 greatly increases the functional capacity of the foot, yet enables the patient to wear the conventional type of footwear. Use of this product, in con-

*Presented at Annual Meeting, National Association of Chiropodists, Chicago, Ill., August, 1957.

tradistinction to the so-called molded shoe and the impression-type inlay, produces a dynamically molded appliance—an appliance formed while the patient is in the state of locomotion as well as in the static position.

This molding material (Contur-A-Mold®[1]) is composed of ground cork and leather fiber which, when mixed with a latex of special formula, produces a soft mass that can easily be spooned and then shaped inside the patient's shoes. Following application of the material within the shoe, a separator solution consisting of a weak acid is sprayed over the area, causing an initial setting of the material. The equipment necessary for the proper application of Contur-A-Mold consists of (1) a mixing bowl (one quart size), ceramic or plastic; (2) a tablespoon; (3) a teaspoon with the handle bent up 45°; (4) a spray-pump similar to those used for spraying medications or cosmetic lotions.

The material is mixed in the ratio of 3 level tablespoonfuls of the fiber to 1 level tablespoonful of the latex, for approximately 60 seconds. The amount of fiber and latex will vary with the size of the shoe, and the size of the appliance to be constructed. The 3 to 1 ratio, however, must always be maintained.

The construction of a medium to medium-large full foot mold, which incorporates crest therapy, requires approximately 12 tablespoonfuls of the fiber and 4 tablespoonfuls of the latex for one shoe. Just enough for one shoe is mixed at a time. The mixed compound is then spread over the insole, starting at the tip and working back toward the shank. The compound should be spread out to slightly less than ⅛ inch thickness over the entire tread area of the insole, with shaping and smoothing as the material is applied. Following the application of the material, the separator solution is sprayed into the shoe, and the anterior half of the mold is covered with a piece of sheet-plastic to prevent scuffing the top of the mold. The sheet-plastic is of the type used to bag vegetables in grocery stores and can be obtained in any dry-goods store. The stockinged feet are then carefully placed in the shoes and the patient is instructed to leave the shoes on for at least three hours. Walking during this period is encouraged. At subsequent visits more material can be applied over the existing mold at the operator's discretion.

The construction of a rear foot appliance is similar to the full foot mold, except that approximately 9 level tablespoonfuls of the fiber and 3 level tablespoonfuls of the latex are mixed together for each shoe. The material is spatulated into the shoe beginning at an area just posterior to the position of the metatarsal heads and working towards the heel. A piece of plastic sheeting is used to cover the mold to prevent scuffing.

Contur-A-Mold has a diversified use. Plantar excrescences are easily accommodated simply by placing a ⅛ inch or thicker adhesive felt over the excrescence on the patient's foot. The foot is then placed in the shoe which has just been prepared with Contur-A-Mold. An indentation which has been dynamically molded is the result. The material has been successfully used in treatment of forefoot lesions as well as for calcaneal spurs, and for flabby heels so often seen in aged patients. The dynamically molded appliance can remain stationary in the shoe, or can be removed, trimmed, and covered with leather, thus making a durable removable appliance adaptable to other footgear.

Contur-A-Mold affords the patient an individual "doctor-created" dynamically molded appliance in the patient's own conventional footgear. Its application is much less messy and probably less time consuming than many casting techniques.

1418 Plainfield Ave., N.E.

[1] Professional Products Co., 31 Houston Ave., Muskegon, Mich.

A SIMPLE METHOD FOR TREATING FRACTURED TOES

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West Hartford, Conn.

MUCH has been said and written about treating fractured toes and various methods of splinting them have been employed by us, some favorably and others less so. Whatever method works well for you is the one you should continue to use but with an open mind for a better and easier one. The following method offers simplicity of fabrication, durability and tolerance of the material employed, and minimum of discomfort and disability to the patient.

Properties

This method utilizes the favorable properties of celastic to accomplish immobilization of the fractured and dislocated toes. The material is light weight, durable thin, easily molded over the area treated, and non-sensitizing if worn for a long period of time. The aforementioned physical properties of celastic eliminates the need for cutting away the anterior portion of the patient's shoe and the necessity of making additional celastic splints upon return visits for physical therapy, etc.

Discussion

Before proceeding with the technic employed, it is essential that one very important point be brought out. The essential point is that it is imperative to restrict motion at the metatarso-phalangeal joint of the corresponding fractured toe. If motion is not restricted at the base of a fractured toe, the extensor and flexor digitorum muscles with all their inserting muscles continue to contract and relax during the take-off phase of walking, thus prolonging the recovery time. Many of us who splint a fractured toe to the adjacent one without providing any means of limiting metatarso-phalangeal motion are in reality accomplishing very little for the security and protection of the patient while allowing them to remain ambulatory. The fact is, the fracture would have healed in spite of treatment. The proof of this matter is that if one applies force against the palmar side of the distal phalanx of the finger (metatarso-phalangeal structures of the hand and feet are similar) and continues the pressure, pain will be felt at the metacarpal-phalangeal articulation and not at the proximal or distal interphalangeal joint. Restriction of motion of the toes while walking is accomplished at the metatarso-phalanged joints.

Technic

If any bones of the 1st or 2nd toes are fractured, the toes are splinted together in a common celastic jacket and if any bones of 3rd, 4th, 5th toes are fractured, the three toes are used as an anchor for the toe jacket. The reason that the adjacent toes are included when only one toe is fractured is that the celastic toe jacket fits and seats better on the foot if the above method is used. (See Fig. 1), Celastic jackets for fractured toes.

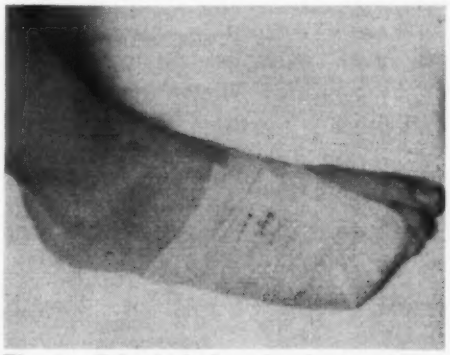


Fig. 1 — Celastic jackets for fractured toes

Splinting the adjacent toes together with adhesive tape is optional, but the author has found that its use further secures the fractured toe. Place lamb's wool in-between the splinted toes instead of regular cotton. Using an eye measurement, cut-off two 1/16 (No. 75) pieces of celastic long enough to cover the dorsal and plantar surfaces of the involved toes and one-half

of its corresponding metatarsal. If the fractured toe is sensitive to pressure, anesthetize the area with your choice of anesthesia. (Ethyl chloride is inadequate for this procedure.) Place petrolatum or lanolin over the adhesive taped area and the adjacent skin in order to protect it from acetone or celastic softener. Place the two pieces of celastic strips you cut on a piece of wax paper and spray with celastic softener individually. Dipping celastic strips into container usually makes the celastic too wet and soft. While the celastic is soft and pliable, mold one piece of celastic over the fractured area and adjacent toes. Then place the second piece a little posterior to the first piece and mold it, thus giving it a skiving effect. If the 3rd, 4th, and 5th toes are splinted, slide the celastic that seems to be overhanging the outside of the foot over to the medial side and shape to metatarso-phalangeal area. Cut off excess celastic on outside of foot with heavy scissors after pinching outer edges together. This will leave an opening on the lateral aspect of the splint from the middle of the 5th metatarsal shaft to the base of the 5th toe. Cover this linear opening with the thinnest piece of celastic you have. (The reason that the outside is trimmed and recovered with a thin piece of celastic is that there usually is very little width room to spare in even roomy shoes.) If the first or second toe is splinted, place one piece of thin celastic over the entire area splinted including the medial aspect of the foot and toe in order to avoid a ridge that might serve as a source of irritation to a bunion. The dorsal and plantar surfaces are then reinforced with additional celastic pieces and molded into place. Areas to be trimmed are marked off with an ink pencil. Particular attention should be paid the toe area where the sharp edge of the celastic could irritate the skin of the adjacent toe if the celastic edge extends over too far. Moleskin should be placed under sharp edges to prevent irritation of underlying skin.

Mold the celastic under the toes and into the web thus making a good seat for it on the foot. Using a hair dryer, dry the celastic for 10 or 15 minutes, and remove it from the foot when almost dry. Do not make any adjustments or trim until celastic has completely dried overnight. The patient is further strapped to provide maximum amount immobilization with adhesive tape and told to return the following day at which time adjustments are made on foot to make sure of fit. Sharp edges and points can be rounded by grinding.

Summary

A practical office procedure for treating fractured toes has been described. Its evaluation can only be interpreted by using it and comparing it with other methods, such as acrylics and plaster of paris splints. The author has found the disadvantages of celastic splinting to be far less than all other methods employed without sacrificing therapeutic efficiency.

309 North Main Street

"Labor disgraces no man; unfortunately
you occasionally find men disgrace labor."

Ulysses S. Grant

WELCOME TO WASHINGTON

The Capitol

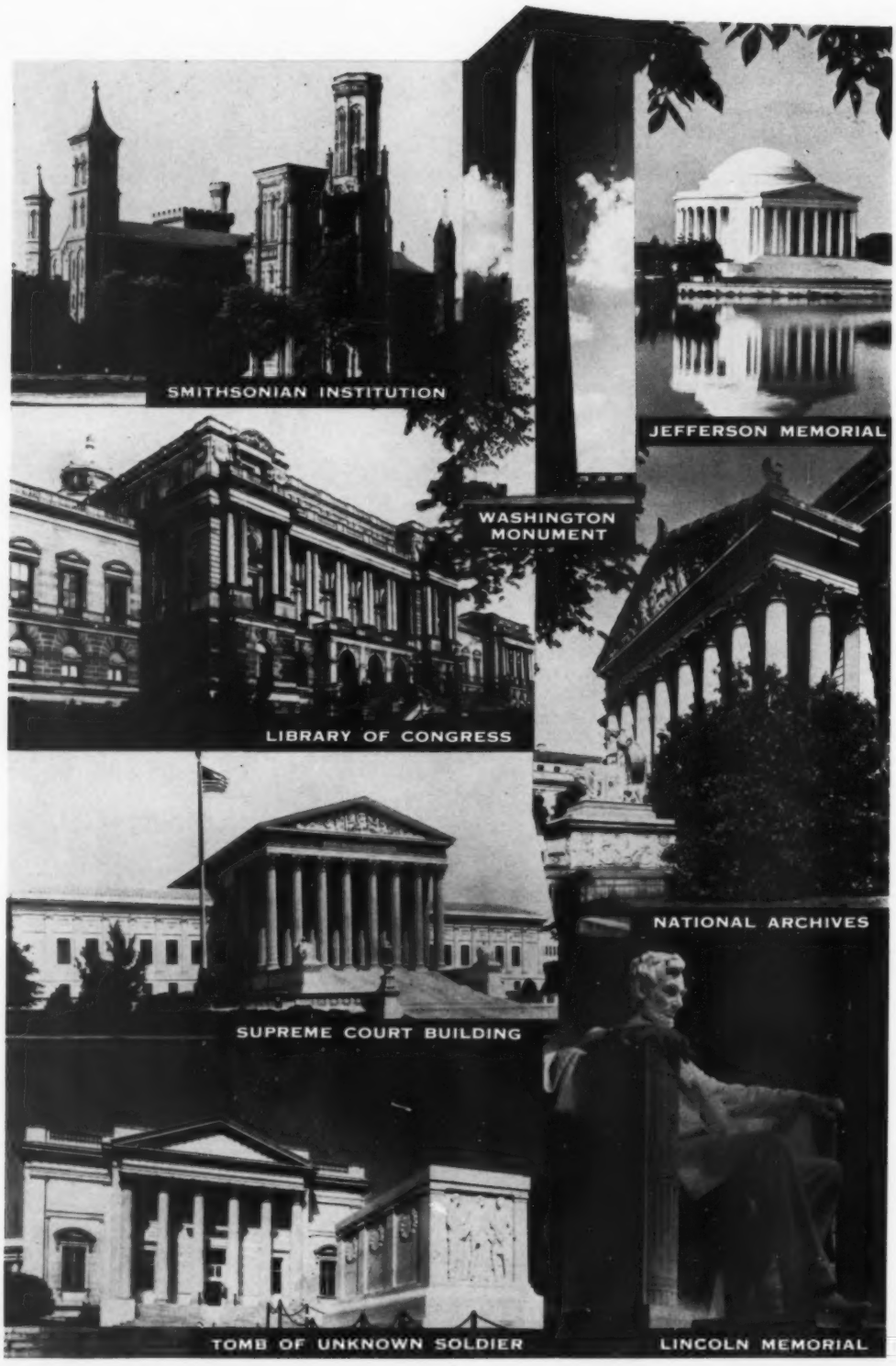
For the first time since 1932, the annual convention of the National Organization will be held in the nation's capital, a city of monuments, August 22-26, 1958.

Of course, everyone knows the historic significance of Washington and its reputation as the world's most beautiful capital. We expect that this year the occasion of the annual meeting will present an opportunity for the members to bring their families to visit the nation's shrines and places of national interest.

In these few pages we have tried to picture some of them for you — the Capitol, where our Congress holds its sessions, is one of the oldest buildings in Washington. Sight-seeing tours through the Capitol are conducted daily by professional guides; the Washington Monument, a memorial to George Washington, affords a scenic view of the historic buildings around it; Jefferson Memorial which is surrounded by blossoming cherry trees in early spring; Lincoln Memorial in Potomac Park; Tomb of the Unknown Soldier, located in Virginia on a hill opposite Washington; Smithsonian Institution, midway between the Capitol and the White House; Library of Congress, directly opposite the Capitol; Supreme Court Building, opposite the Capitol; National Archives and the Art Gallery on Pennsylvania Avenue West of the Capitol.

Some of the educational institutions located in Washington and vicinity are the American University, Maryland University, George Washington University, Catholic University, Georgetown University, Columbus University, Benjamin Franklin School of Accounting and Howard University.

Among the many other places to visit is the National Medical Library, Medical Museum, St. Matthews Catholic Cathedral,


SMITHSONIAN INSTITUTION
JEFFERSON MEMORIAL
WASHINGTON MONUMENT
LIBRARY OF CONGRESS
NATIONAL ARCHIVES
SUPREME COURT BUILDING
TOMB OF UNKNOWN SOLDIER
LINCOLN MEMORIAL

Franciscan Monastery, National Presbyterian Church attended by President Eisenhower, Ford's Theater where Lincoln was assassinated and Dumbarton Oaks.

For entertainment you may wish to visit the Watergate, located on the Potomac where operas and musical concerts are given throughout the summer; also Carter Barron Amphitheater, located on Northern Connecticut Avenue, where you may see Broadway productions. Of particular interest to the younger children will be the boat ride to Mount Vernon or Marshall Hall Amusement Park, a trip to the zoo to see the animals, Glen Echo Amusement Park and a ride around the Tidal Basin.

Sight-seeing tours for members and their families are being arranged to start directly from the Shoreham Hotel at regular intervals. Schedules of these tours will be made available to everyone.

Mount Vernon

White House

This is an excellent opportunity to combine your vacation and the convention, and with the Labor Day weekend following the meeting, you may wish to continue your trip and visit other nearby places of interest, such as Williamsburg, Annapolis and Gettysburg.

The White House, one of the first public buildings to be erected in Washington, has been the home of the Presidents of the United States for more than a century and a half. The White House now has 132 rooms and 20 baths and showers. Portraits of several Presidents hang from the walls of the lobby, main corridor, and rooms of the first floor. You will want to see The East Room, The Green Room, The Blue Room, The Red Room, The State Dining Room, The Private Dining Room. The impression of simple dignity conveyed by the White House is enhanced by the natural beauty of its informal but carefully landscaped grounds. Many of the trees are of historical interest, such as the magnolias planted by Andrew Jackson. In front of the north portico, English boxwood, as old as the White House itself, has been planted. Flower gardens and well-kept lawns add to the beauty of the grounds and Lafayette Park may be seen directly across from the White House.

Mount Vernon was the home of Washington, where he lived in his later years and died. The building and the grounds are much as they were in the President's time. A tramp through the garden with its rose beds, edged by English boxwood, and the view of the Potomac from the front lawn will never be forgotten.

JOURNAL

OF THE

AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

PUBLISHED UNDER THE DIRECTION OF THE EXECUTIVE COUNCIL BY THE AMERICAN PODIATRY ASSOCIATION

3301 Sixteenth Street, N.W., Washington 10, D. C.

A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

PRESIDENT'S MESSAGE

Progress consists not in the declaration of progressive programs but rather does it consist of translating those progressive programs into action. With this issue of our Journal, a substantive progressive transition takes place in response to public demand. The change to Podiatry by our House of Delegates reflects its determination that our profession shall not only move ahead, but that it do so with all deliberate speed.

It is, of course, our young practitioners, both present and future, who will reap the harvest of the progressive changes which we are endeavoring to effect. Accordingly, it is incumbent upon them to accept increasing responsibility for our professional stature. The young Podiatrist must learn to contribute of himself to his state and national organization so that the greatest possible public good will be achieved.

It can be the unfortunate inclination of the new practitioner to ignore the responsibilities of the profession as a whole and to concern himself only with his personal fortunes. Progressive ideas originate mainly with the young. The more mature colleagues are able to provide the wisdom and experience necessary for its translation into action.

The official change to the term Podiatry is, of course, but a single spoke in the large wheel of progress. This evolution in our profession crystallizes for us our manifold responsibilities. Accordingly, this is the time for reaffirmation of our devotion to ever-increasing professional standards. We must carefully analyze the public needs for our services and create the machinery necessary to provide them. We must enlist, in tremendously increasing numbers, students for our colleges so that the anticipated public need can be met. Most of all, we must meet the challenge of this dynamic age in the quality and quantity of our educational facilities.

Your President is well aware of the emotional impact this change creates on some of us. History is replete with the evidence of such anguish. Your President not only understands the intensity of such feeling, but must confess that

frequently he sympathizes with it. However, any individual who aspires to the privilege of holding the high office of President of his national professional organization has it encumbent upon him to have the courage to accept and promote the changes necessary for growth, development and progress, never losing compassion for those who are distressed because the past is no more. It is to this broad spectrum that your President aspires.

My congratulations to each and every member of the American Podiatry Association, and may God bless us all.

JONAS C. MORRIS, D.S.C.

AMERICAN PODIATRY ASSOCIATION

The Official Publication of our Profession has been known successively as "Pedic Items" (1907-1920), "Journal of the National Association of Chiropodists and Pedic Items" (1921-1939), "Journal of the National Association of Chiropodists-Podiatrists" (1940-1948), "Journal of the National Association of Chiropodists" (1949-1957), and with this issue it becomes the "Journal of the American Podiatry Association."

Each of these changes occurred as the result of due deliberation and action of our elected representatives. In 1948 the House of Delegates, attempting to establish a uniform terminology for our profession, adopted a resolution directing that only declensions of chiropody be used in publications and literature of the National Association.

This obviously did not produce the desired result. In 1956, the House of Delegates referred the question to the Executive Council for further study and report to the 1957 House of Delegates. After much debate and due deliberative democratic process, the 1957 House of Delegates voted 48 to 16 to amend our Constitution by changing the name of our professional organization to the American Podiatry Association, permitting individuals, state societies, our institutions and other of our professional agencies to use the term of their choice.

Your Editor, a former champion, and frequently a vociferous one, of chiropody, now fervently hopes that all of us will, upon due consideration accept Podiatry as the term best expressing our capacity to serve the public. Your Editor believes that the failure of the profession and the public to accept the term Chiropody in preference to Podiatry was due to the fact that, although Chiropody is a term we may prefer, Podiatry is the term our public, other professions, and public and private agencies prefer for "foot doctors."

The term Podiatry will solve few of our problems. The change itself encounters difficulties and obstacles. But these become mechanical details in the face of a will to accept our responsibilities as the only agency dedicated solely to the nation's foot health, responsive to the public we serve.

Eighty-fifth Congress, Second Session

By the time this column is in print, the Eighty-fifth Congress will have returned to Washington for its Second and final Session. It will find a very definite change in the political atmosphere. The problems of the Middle East which the President had designated as number one in the matters to be considered by Congress in its First Session remain the principal subject for the Second Session, but their importance has been greatly emphasized by the antics of the Russian Sputnik. As a result, items of the budget that were seemingly satisfactorily solved for this administration will require immediate review.

From our point of view you will recall we considered health matters would be a considerable concern of the returning Congress, because at that time the Nation was threatened with an epidemic of Asian flu, and while poliomyelitis cases were decreasing in number as a result of the widespread use of the Salk vaccine, nevertheless it was reported that in spite of the intensive effort made to immunize the population, about 45 million Americans under 40 had received no vaccine protection against paralytic polio. We forecast at that time that bills relating to health and welfare would be among the first to be considered by Congress.

Fortunately, the Asian flu did not prove to be the scourge that some prophets had pictured, and the retreat of poliomyelitis has continued. Welfare bills will retain their interest, but they will likely give way to educational bills.

Research Grants

Surgeon General Leroy E. Burney reports that the Nation's health research facilities have received in the first two years of a three-year grant program, at least $120 million of Federal money, which means that at least an equivalent amount has been provided by the participating institutions. The $60 million appropriated by Congress for the fiscal years 1957 and '58 has been entirely allotted, with the 43 new grants totaling $3,698,452 recently allotted. These grants went to 39 institutions in 22 States, the District of Columbia, and Hawaii. A total of 150 institutions—hospitals, universities, research institutes, schools of medicine, osteopathy, dentistry and public health—are now participating in the program.

Dental Health Institute has received $3,825,000 for research and fellowships. Another $1,184,000 has been given directly to the Bethesda Institute for research.

Advancement in Education

But the ballistic missile program has moved to the front of the stage, and the public's attention is concentrated with increasing intensity upon research. Only now the aim is to increase the number of engineers, as well as doctors. Our educational achievements have been challenged. Congress will feel that it must devote more attention to our schools. There has been a growing demand for improvement of our schools and colleges. Corporate giving to education has risen from $20 million in 1951 to $100 million in 1956. However, many companies report they still experience difficulty in finding skilled engineers, particularly electronic engineers.

The United States Office of Education found that there were about 3 million "degree credit" college students enrolled last year. Although this was a record-breaking total, the experts hope it is only the beginning of a continuing trend and that by 1977 the Nation's colleges and universities may have a total enrollment of 6 million students. Enrollment in Russian higher educational institutions has in-

creased from 169,000 in 1927 to 1,867,000 last year, the Department of Health, Education and Welfare reports. During the same period enrollment in United States colleges and universities increased from 1,114,000 to 2,996,000. The number of graduates has increased almost four times in the USSR within the past decade.

In spite of some of the disturbing reports we are hearing that education in Russia surpasses that in the United States, the Department states that between 8% and 12% of all college-age students in the USSR are enrolled in higher education institutions, either part or full-time, while in the United States, 25% of college-age students are similarly enrolled. In Russia 50% of the student body are women, while in the United States only about 37%.

Medical School Enrollment

To return to the health field, a report from the American Medical Association states that of every 100,000 persons in the United States, 4.7 were enrolled as freshmen in American medical schools during 1956 and '57—a record enrollment. The total number of students enrolled in the 78 four-year approved medical schools and four schools of two-year basic medical sciences in the United States, was 28,852, as over against 28,639 students enrolled in 1956-'57.

Research Training

The training of individuals in research has been more particularly developed in the health field, and large sums of money have been appropriated by Congress for this purpose. The threat of the ballistic missile is bound to draw enormous sums to the development of research in the field of defense, where there is great need for intensive study and investigation. But it must be remembered that not all students, regardless of the amount of money and favorable facilities, can become contributors to science. There seems to be truth in the adage that a scientist is born, and not made.

The Older Person in the Home

The Department of Health, Education and Welfare has announced the production of a 34-page booklet entitled, "The Older Person in the Home." The booklet points out that according to a recent estimate of the Bureau of the Census, about 3 million older people in the United States are living in the homes of married children or other close relatives. The latest tabulation of reports from the States shows that there were 2,498,000 older persons on the public assistance rolls during August, the first time the total has been below 2½ million since 1948. Assistance payments now are made to 167 out of each 1,000 persons over 65 years of age, in comparison with 226 per 1,000 in 1950. This decline in the number of persons receiving old age assistance reflects in part the number of aged people who receive benefits under the Federal Old Age and Survivors Insurance program, which is not considered old age assistance. Three out of four people reaching age 65 this year will be eligible for such Insurance benefits. Persons added to the old age assistance rolls are those who fail to qualify for Old Age and Survivors benefits or have little or no other independent income.

"Education is a privilege but it involves the responsibility of leadership.

Clarence B. Randall

REPORT OF THE EXECUTIVE COUNCIL MEETING

The full Executive Council met in Washington, D. C., at the Woodner Hotel, November 22, 23, 24, 1957. Perhaps the most significant event of the meeting was the adoption of the resolutions implementing the will of the House of Delegates to change the name of the association from the National Association of Chiropodists to American Podiatry Association. These are:

WHEREAS the House of Delegates of the National Association of Chiropodists at its last annual meeting has directed that this Association shall henceforth be known as the AMERICAN PODIATRY ASSOCIATION and

WHEREAS the Executive Council has determined that in order to effect the mandate of the House of Delegates, it would be to the best interest of the membership to apply for a new corporate charter under the name of American Podiatry Association and

WHEREAS such a charter has been obtained in accordance with the laws of the District of Columbia, effective November 4, 1957.

NOW THEREFORE

BE IT RESOLVED by the Executive Council of the National Association of Chiropodists that

1. All activities formerly carried on under the name of NATIONAL ASSOCIATION OF CHIROPODISTS will henceforth be continued under the name of AMERICAN PODIATRY ASSOCIATION, subject to the approval of the governing body of the latter organization, and that

2. The appropriate officers of this Association are hereby authorized and directed to execute all necessary documents for the transfer of any and all property, of whatsoever kind, now owned by this Association to the AMERICAN PODIATRY ASSOCIATION so that good and sufficient title to all such property will vest in the AMERICAN PODIATRY ASSOCIATION, a District of Columbia corporation, as the successor in interest to all property and all of the affairs of the NATIONAL ASSOCIATION OF CHIROPODISTS, subject to any liabilities, liens or encumbrances, now in existence with reference to such assets, such transfers to be effective with the adoption of this resolution or as soon thereafter as the appropriate instruments have been executed and

BE IT FURTHER RESOLVED that the existence of the NATIONAL ASSOCIATION OF CHIROPODISTS, as a corporation organized under the laws of the State of New York shall continue, notwithstanding anything contained in the foregoing resolutions, for so long as such existence shall be permitted by law.

RESOLUTION OF EXECUTIVE COUNCIL OF NATIONAL ASSOCIATION OF CHIROPODISTS

WHEREAS the House of Delegates of the NATIONAL ASSOCIATION OF CHIROPODISTS at its last annual meeting has directed that the National Association of Chiropodists shall henceforth be known as the AMERICAN PODIATRY ASSOCIATION and

WHEREAS to effect the mandate of the House of Delegates, a new corporate charter under the name of AMERICAN PODIATRY ASSOCIATION has been obtained in conformity with the laws of the District of Columbia, effective November 4, 1957 and

WHEREAS the Executive Council of the NATIONAL ASSOCIATION OF CHIROPODISTS in a resolution adopted November 23rd, 1957, has directed that all activities formerly carried on under the

name of NATIONAL ASSOCIATION OF CHIROPODISTS be continued under the name of American Podiatry Association, subject to the approval of this body, and

WHEREAS the Executive Council of the NATIONAL ASSOCIATION OF CHIROPODISTS as part of the same resolution has directed that, all property owned by it of whatsoever kind, be transferred to this Association, subject to any existing liabilities, liens or encumbrances.

NOW THEREFORE

BE IT RESOLVED by the Executive Council of the AMERICAN PODIATRY ASSOCIATION that

1. All activities formerly carried on under the name of NATIONAL ASSOCIATION OF CHIROPODISTS, henceforth will be continued under the name of AMERICAN PODIATRY ASSOCIATION and that

2. The appropriate officers of this Association are hereby authorized and directed to take such steps as are necessary to acquire title and take possession of the abovementioned property, including, but not limited to, the opening of all necessary bank accounts, and the registration of any savings bonds or other securities in the name of this Association and

BE IT FURTHER RESOLVED that

3. All members of the National Association of Chiropodists in good standing as of this date are hereby made members in good standing of the American Podiatry Association and that

4. The Constitution and By-Laws of the NATIONAL ASSOCIATION OF CHIROPODISTS in effect as of this date are hereby adopted as the Constitution and By-laws of this Association.

RESOLUTION OF EXECUTIVE COUNCIL OF AMERICAN PODIATRY ASSOCIATION

Reports from the various committees of the Association were received and considered by the Executive Council.

Upon recommendation of the Budget and Fiscal Committee, unallocated committee funds were distributed to the various committees. The change in name in the month of January prompted the allocation of $2250.00 to use this occasion to increase the public awareness of our profession.

This fund is to provide:

1. State society information kits on how to use the name change to develop this public awareness.

2. Information to individual members.

3. Announcement cards which individuals and state societies may use to further widen our circle of friends.

4. News releases to all wire services, radio and TV news media, newspapers, national and professional periodicals.

5. Personal letters to a selected list of universities, colleges and individuals in other public and private agencies.

Another major decision was to allocate $1000.00 toward the establishment and development of a fund for the advancement of podiatry-chiropody education. This resulted from the preliminary report given by the special committee appointed by Dr. Morris, for which Dr. Horowitz is the Chairman, implementing Resolution 55, adopted by the 1957 House of Delegates.

Joseph S. Lawrence, M.D., our Consultant, was asked to assume more duties in our headquarters as an interim measure until more permanent staff arrangements are made at national headquarters.

A preliminary report on the Medical Service Plan Advisory Service survey was received. It is anticipated that this project will be completed the early part of 1958.

Complete report books of the proceedings are being made available for Presidents and Secretaries of all State Societies, Delegates and Alternates to the House of Delegates and all National Committee Chairmen.

REPORT OF THE EXECUTIVE COUNCIL SUB-COMMITTEE ON DUAL TERMINOLOGY*

The 1956 House of Delegates referred the terminology problem to the Executive Council for study. As it is the policy of the Executive Council to appoint sub-committees to deal with various facets of the organization of the N.A.C., President Gamble appointed a sub-committee to study the problem from every angle and report to the Executive Council and to the House of Delegates in 1957.

This report concerns itself with the individual collective efforts of the committee members with the hope of solving what might be said to be an "age-old" problem because the issue of dual terminology has existed since before 1920. At the outset the committee fully comprehended that we were confronted with a problem which we realized should be solved at once; however, being realistic and taking cognizance of the past history of our profession, optimism was not at the scene of the deliberation.

An analysis of our problem and the past efforts made to solve it may reveal a very important point . . . that analysis being that the committee members, to be effective in solving this terminology confusion, must submerge any and all personal feelings regarding one term or the other. We must set forth unbiased facts, data, and conclusions in the briefest possible form so that the House of Delegates and the membership at large might judge for themselves the best course for the "foot-doctoring" profession.

The committee would like to make it abundantly clear that they are not taking side . . . either for or against one term or the other . . . but rather are presenting an analysis with an earnest desire and hope that it will cut short the time that it takes for our profession to decide on a single terminology and avoid confusion.

With this premise established, we would like everyone to realize that if the profession were given sufficient money so that adequate radio, television, newspaper, and magazine advertisements could be purchased, either term, "chiropodist" or "podiatrist," or any term, could be made to designate to the public that it signified one who treats feet.

It is a pretty well established fact that approximately ten per cent of the public knows what a "foot doctor" is. If we accept that as a fact, it would seem logical that it would be to our profession's benefit to establish at the earliest possible date a single terminology and bend every effort toward educating the untouched ninety per cent of the general public to the need for foot care. This ninety per cent of the people who are unacquainted with the "foot doctors" little realize the importance of foot health to their general well being. It is our desire as a profession to assume our full responsibility to the entire population of the United States; therefore, it is necessary for us as a profession to educate all the people as to the value of foot health. It would seem that this is an opportune time to solve the dual terminology problem and go forward as a unit to accomplish this goal.

We should like also to point out that it is possible for our profession to continue with the confusion of dual terminology. We're all aware that it does now cause confusion but will certainly not bring about disintegration of the "foot doctor" . . . so far as the public is concerned.

In proof of that point, we might illustrate with the law profession where we have lawyers, attorneys at law and counsellors at law. We're sure that the legal profession generally does very well and it is obvious

that we may continue as we are with dual terminology.

The committee would further like to call to your attention the fact that regardless of the medical terminology used, from a practical standpoint, so far as the public is concerned, it makes no difference whether we are chiropodists or podiatrists. To the public we will be "foot doctors." As evidence of this, we should like you to attest that practically no one outside of the medical field could pronounce "ophthalmologist"; nevertheless, it is quite evident that the public is fully aware that the ophthalmologist is the professional man who uses medicine in the eyes, does surgery, etc. In spite of the fact that the public is not able to pronounce the word, it can clearly delineate the professional scope of the ophthalmologist from the optometrist.

Previous surveys made show that the term "chiropody" is a better known term than "podiatry" . . . as far as the ten per cent already familiar with the "foot doctor" are concerned. This is no doubt the reason those favoring "chiropody" felt the minority favoring "podiatry" were wrong. There has been an apparent lack of realization that minorities may be right.

An analysis of the previous past history in the efforts made to solve the dual terminology problem points out possible reasons for failure because of insufficient study and therefore inadequate presentation of data for the membership to use in determining a solution.

History reveals that decisions were guided by factionalism and fear; factionalism being geographic; fear being on the part of men in practice who are apprehensive that a change in name would suddenly cut them loose, they would be adrift, and the public would no longer be able to find their offices which would consequently lower their income. Clear thinking about what is best for the profession was absent.

There is another facet of our profession who feel that a change to a semantically correct name will solve all of our professional troubles. In the minds of the committee, this line of reasoning is in the realm of dreams and certainly not true. It is agreed that being a scientific branch of the healing arts we should have a semantically correct designation; however, it will still be necessary to make the same efforts to educate the public as it would with dual terminology. Perhaps the effort necessary would be slightly less but being semantically correct is not a panacea. We will always be rated on our scientific achievements rather than a designation semantically correct or incorrect.

It is particularly distressing to the committee to see history repeating itself in the 1957 House of Delegates because of resolutions presented that could cause a repetition of past history. We believe it is eminently clear that those efforts have failed, and will continue to fail because it is not the proper approach to solve the problem.

The committee is well aware of the fact that "chiropody" is much the better known term among the ten per cent of the population who are familiar with "foot doctors." We are also cognizant of the fact that the term "chiropody" has connotations of "corn doctors." (It is the professional man's fault if the patient who consults him thinking he is only a "corn doctor" leaves his office still thinking he is only a "corn doctor.")

We are aware of the fact that chiropody is confused with chiropractic by many. While we are not pleased about this, it is no major problem and is not to be given too much consideration. We are aware that chiropody is mispronounced many times. We are equally cognitive that podiatry is mispronounced. Podiatry is confused with pediatrician, etc. We would like to take either designation and make it well known to the minds of the public; however, if we

are to stick to facts, we should like to point out that chiropody is semantically incorrect. The word "chiropodist" is derived from the Greek word *Cheir,* meaning "hand," and *pous* or *pod,* meaning "foot." Podiatry is semantically correct. It is derived from the Greek *pous (pod),* meaning "foot," plus *iatros,* meaning "physician." Chiropody is more widely known; podiatry is less widely known. To summarize, chiropody is confused with chiropractic; podiatry is confused with pediatrician. Chiropody is mispronounced; podiatry is also mispronounced. We would like to emphasize that our terminology should be semantically correct. We need not be alarmed about whether the public can pronounce it or not. We can and will cause that term to mean to the public . . . "foot doctor."

With these thoughts in mind it becomes clear that it would be possible for us as a profession to elect a designation that would be semantically correct, therefore, satisfy the semanticists, educators, and government agencies. This would put us on a sound scientific basis as to a name without one small bit of harm being noticed in the way of loss of practice by anyone who practices today. In fact, any well-established practitioner could remove the title of "doctor" from his door and his window without a noticeable depreciation in practice. The thought the committee is trying to get across to those in practice is that a change in a name will in no way increase or diminish a going practice. We are emphasizing these points so that members of the profession may be guided in helping to solve this dual terminology problem on merits rather than fear or emotionalism of any type.

We should not attempt now or at any future time, to force a minority to conform as this committee is not naive enough to feel our association, constituted as it is, would have either the power or the prestige to force a minority to conform. May we remind you that the National Association is an association of forty-eight societies and the District of Columbia joined together as a National Association with the various state societies having considerable autonomy; therefore, it is easy to see why it is folly, as has been proven in the past, for a majority to try to cause state societies, by coercion, to be changing their terminology.

After a careful analysis of the pros and cons and all the facts available, and after a review of the past history of our profession and the efforts to solve this problem, the committee recommends that if we do not have the wisdom at this moment to solve the dual terminology problem, then the second best thing to be done is to continue the dual terminology, use it freely, and let time, individual states, and individuals choose the term which they believe is better. It is the studied opinion of the committee that the term "podiatry" will eventually be the designation of the "foot" profession; therefore, we recommend a gradual changeover to the term "podiatry."

Respectfully submitted,

Sub-Committee on Dual Terminology
G. E. Guenzler, D.S.C., Chairman
Alec C. Levin, D.S.C.
Raymond K. Locke, D.S.C.
Charles R. Brantingham, D.S.C.

•Presented to the 1957 House of Delegates, National Association of Chiropodists.

"Scholarship isn't the use of obscure words or high-sounding phrases. True scholarship takes the greatest principles and makes them so simple that a child can understand them."

An unknown country preacher

TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and N. H. KETAI, D.S.C., F.A.C.F.S.
Editors, Publications Committee, A.C.F.S.

Illustrated case reports and discussions, suggesting approaches to podiatric surgery, from the files of the American College of Foot Surgeons.

SURGICAL REDUCTION OF A HALLUX VALGUS

A white woman, aged 28, seen in the office, presented a hallux valgus with a mild deviation of the great toe. An adventitious bursa had formed over the medial aspect of the first metatarsal head, and there was a callous overlying this. This was a unilateral condition, and it was difficult for the patient to wear footgear comfortably.

X-Ray findings indicated the usual pathology seen in a hallux valgus.

All laboratory findings were within normal limits. Preoperative blood pressure was normal, and the preoperative oral temperature was 98.8°.

Procedure: Anesthesia to the area was effected by use of Novocaine®[1] 2% in the amount of nine cc. A longitudinal incision five cm. in length was made on the dorsal aspect of the metatarsophalangeal joint, and centered over the head of the first metatarsal. This was just medial to the Extensor Hallucis Longus. Blunt dissection was used separating the subcutaneous tissues and to expose the joint capsule. The capsule was incised longitudinally, superiorly to the joint. An elliptical incision was made in the capsule on the medial side of the joint, and a section of it one-half centimeter wide removed. The metatarsal head was delivered through the capsular incision, and that part of the medial condyle medial to the sagittal groove was amputated with a bone saw. This bone area was then smoothed with a bone file. The capsule which had been shortened as mentioned previously was sutured with six 000 chromic catgut sutures. Subcutaneous tissues and skin were closed by six 000 dermal vertical mattress sutures. The foot was dressed with a sterile pressure dressing.

The patient was given Empirin®[2] with codeine 1 grain every three hours for pain, and Nembutal Sodium®[3] 1½ grs. h.s.

Postoperative treatment was as follows: Sterile redressings of the outer bandage were made on the second, fourth, and sixth days following surgery using pressure dressings. A complete new sterile pressure dressing was made on the eighth day following surgery. The sutures were removed on the twelfth day postoperatively, and sterile dressing applied. The patient was dismissed at the end of four weeks.

Acute disability lasted seven days. Patient was ambulatory thereafter. A cutout shoe was worn for 21 days, and a basic oxford thereafter.

N. Bianco, D.S.C.

Comments: In a mild hallux valgus where there is not much deviation or displacement, and it is desired to eliminate the pressure from the medial side of the first metatarsal head, this is one of the procedures used.

L.R.M. and N.H.K.

SURGICAL REDUCTION OF A HALLUX VALGUS

A white woman, aged 48, seen in the hospital presented an excessive osseous hypertrophy on the medial side of the head of the first metatarsal. There was a mild valgus of the great toe. There was extreme

®[1] Winthrop ®[2] Burroughs Wellcome & Co. ®[3] Abbott

tenderness over the great toe joint and the patient was unable to wear proper shoes. There also was a large adventitious bursa overlying the area.

Urinalysis revealed the following: Color —amber characteristics—clear reaction—acid specific gravity—1.014 albumin negative. Blood chemistry for sugar findings were negative. Hemoglobin was 78%, W.B.C.—7,500, R.B.C. 4,780,000. Preoperative blood pressure 142/82 and preoperative oral temperature 98.6.

Procedure: Anesthesia was effected by Pentothol Sodium.®[4] A curved incision six cm. long was made over the dorsal aspect of the great toe joint. The superficial tissues were bluntly dissected and retracted. The bursa was exposed and resected, exposing the joint capsule. The capsule was incised with a U-shaped incision, the free edge of the flap being proximal. Bleeders were tied off with 000 chromic catgut as they were encountered. The metatarsal head was exposed, and that part of the condyle medial to the sagittal groove was removed with chisel, mallet and bone rongeurs. The area was then smoothed with a bone rasp. The conjoined Adductor Hallucis was severed from its insertion and sutured into the periosteum of the lateral aspect of the first metatarsal head. The capsular flap was shortened and sutured into position with seven 000 chromic catgut sutures. The skin incision was closed with twelve mattress sutures of 000 dermal. Two minims of hydrocortisone acetate were injected subcapsular into the joint. A sterile pressure dressing was applied to the foot.

Demerol Hcl.®[5] was given every four hours for severe pain, and Dramamine®[6] every four for nausea.

Postoperative treatment was as follows: Sterile redressing was made the following day. On the fifth postoperative day the patient was dismissed from the hospital. Sutures were removed on the tenth postoperative day, and sterile dry gauze dressing applied. Gauze dressings and hydrotherapy were used on the thirteenth, seventeenth, and twenty-first days after surgery. The patient was dismissed at the end of the fourth week.

The patient began walking on the fifth postoperative day with shoes that were cut out. The patient returned to regular shoes at the end of three weeks.

Donald T. Gartner, D.S.C.

Comments: This is another of the procedures used for the correction of hallux valgus. By severing the tendons of Adductor Hallucis and suturing them to the lateral side of the metatarsal head muscular action is also used to help keep the metatarsal in the desired position.

L.R.M & N.H.K.

®[4] Abbott

®[5] Winthrop

®[6] Searle

To achieve success in medicine you must give of the very best of your knowledge and skill and give it gladly and cheerfully, so that your patients will want to come back to you and send their friends to you.

AOP

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Lowilla

Description: A non-irritating, only mildly defatting skin detergent of low sensitizing index, containing sodium lauryl sulfoacetate, for use as skin cleanser and soap substitute in dermatoses, particularly eczematous dermatitis, industrial dermatoses and conditions caused or aggravated by the use of soaps.

Supply: Lowilla Cake in 4 ounce cakes. Lowilla Liquid for dishwashing and general household cleansing in bottles of 16 ounces. By Westwood Pharmacal Corp., 468 Dewitt St., Buffalo 13, N. Y.

Meticortelone Acetate

Generic Name: Prednisolone acetate.

Description: Each cc. of Meticortelone Acetate Aqueous suspension contains 25 mg. prednisolone acetate for intra-articular injection.

Action: Meticortelone Acetate exerts marked anti-inflammatory action at tissue level when injected directly into inflamed, non-infected joints. Administered by this route, the hormone produces a purely local effect. Injection of this corticosteroid results in a reduction of joint temperature and a marked drop in synovial fluid cell count. Clinical studies to date suggest an increased duration of effect. Systemic effects have not been observed with intrasynovial or intrabursal injection.

Indications: Meticortelone Acetate Aqueous Suspension intra-articularly is indicated in rheumatoid arthritis, osteoarthritis and post-traumatic bursitis.

Advantages: Intra-articular therapy of rheumatoid arthritis and osteoarthritis with Meticortelone Acetate Aqueous suspension provides sustained relief from pain and stiffness and suppression of acute and chronic inflammation in a majority of accessible joints. Relief in joints so treated generally occurs within 24 hours. Benefit lasts from an average of 8 days to a few weeks in some cases. This suspension is particularly useful: (1) when only one or two peripheral joints are involved; (2) when it is desirable to treat especially resistant or severely involved joints during systemic therapy; (3) when systemic gold, ACTH, or corticosteroid therapy is contraindicated; when systemic dosage must be limited; or when systemic steroids are ineffective; (4) when joint surgery has been instituted or is to be instituted; (5) when it is desirable to ameliorate severity of relapse in one or more joints.

With aseptic precautions, the simple procedure employed in intra-articular injection, injection of this suspension is safe. Untoward effects are rare and usually are mild and self-limiting.

Dosage: Intra-articular; dosage depends chiefly on the size of the joint to be injected. The average dosage injected into larger joints such as knee or hip is 25 mg. (1 cc.). In smaller joints 10 to 15 mg. is usually sufficient. The interval between injections is determined by response in the individual case.

Meticortelone Acetate; for acute bursitis, a single injection of 25 mg. (1 cc.) or occasionally 37.5 mg. (1.5 cc.) is the usual dose. When required, a second injection should be given in 3 to 5 days.

Ray Locke cites this technique for Prednisolone Acetate injection therapy of neuro fibrous heloma, as follows: Cleanse injection area with alcohol sponge and antiseptic. Minimize initial injection pain with ethyl chloride spray. Using tuberculin syringe and No. 25 needle, inject intradermally and subdermally 1 cc. of procaine *very slowly*. *Slowly* inject and disperse desired amount of Prednisolone Acetate into and under lesion. Withdraw needle quickly, blot puncture area, and apply a sterile dressing. Dosage averages 5 mg.

Precautions: Intra-articular use of Meticortelone Acetate Aqueous suspension is contraindicated whenever infection is present or suspected in or near the joints or bursae involved. Systemic effects are not obtained with local injection.

Supply: Meticortelone Acetate Aqueous suspension, 25 mg./cc., 10 cc. vial. By Schering Corporation, 60 Orange St., Bloomfield, N. J.

ACTH

Adrenocorticotrophic Hormone

Description: Brand of adrenocorticotrophic hormone. A colloidal solution, ready to inject.

Action: An essential pituitary hormone which stimulates the adrenal cortex physiologically to secrete its full spectrum of cortical hormones. Has been found to produce dramatic results in the treatment of collagen or connective tissue diseases, such as rheumatoid arthritis, rheumatic fever, acute lupus erythematosus; hypersensitivities such as severe asthma, drug sensitivities, contact dermatitis, most acute inflammatory conditions of the eye; acute inflammatory conditions of the skin such as acute pemphigus and exfoliative dermatitis; inflammatory conditions of the intestinal mucosa such as ulcerative colitis; metabolic diseases such as acute gouty arthritis and secondary adrenal cortical hypofunction.

Administration: Intramuscularly. The dosage varies with the patient and the severity of the disease. In general, a starting dose of 10 mg every six hours may be adjusted up or down to meet the needs of the patient. The therapeutic aim is the lowest dose which will accomplish a clinical result.

Caution: Psychosis, hypertension, active peptic ulcer, congestive heart failure (not due to active rheumatic myocarditis) and chronic nephritis are contraindications to the use of ACTH. Additional insulin is usually required in patients with coexisting diabetes mellitus.

Supply: ACTH Solution, vials 2 cc and 10 cc by National Drug Co., 4663 Stenton Ave., Philadelphia 44, Pa. Also produced by Armour Laboratories, 520 N. Michigan Ave., Chicago, Ill. in vials of 10, 25, 40 U.S.P. Units (I.U.) under the name of Acthar.

Chemical name HP* Acthar Gel is the Armour Laboratories brand of purified adrenocorticotrophic hormone – corticotropin (ACTH). HP* Acthar Gel in potencies of 20 Armour Units, 40 Armour Units and 80 Armour Units per cc, in 5 cc multiple dose vials. Also supplied in a sterile 1 cc B-D cartridge with B-D disposable cartridge syringe in potencies of 20 Armour Units and 40 Armour Units per cc.

Wilson Laboratories, 4221 S. Western Blvd., Chicago 9, Ill. also produces ACTH in a sterile solution in 5 cc multiple dose vials. Item 600: Each cc contains 40 U.S.P. units of corticotropin. Wilson also produces Purified Corticotropin-Gel. The Gelatin menstrum increases the duration of effect and thereby reduces the number of injections required. Supplied in 5 cc multiple dose vials.

ABSTRACTS FROM THE CHIROPODY LITERATURE

ROBERT SHOR, D.S.C.
LOS ANGELES, CALIF.
Chairman, Committee on Publications

Editors of Local, State and Regional Publications are requested to provide copies to the Chairman of the A.P.A. Committee on Publications who is preparing this section of the Journal.

EMERGENCY TREATMENT OF COMA

Paul B. McCracken, D.O., California Newsletter, July 1956.

Sudden loss of consciousness may be classified under four headings each of which demonstrates its nature through clinical signs which may cue the attendant as to immediate care. 1.) Those due to stress and effected through the vaso-vascular mechanism. These are most commonly seen and include (a.) syncope or recessive and (b.) hypertensive or aggressive, and result from sudden or accumulated emotional or physical stimuli. 2.) Traumatic —accidental or surgical. 3.) Endocrine—thyroid, adrenal, and pituitary. 4.) Drugs and poisons in excess. 5.) Organic diseases which may yield coma, resulting when the causative agent exceeds compensatory mechanisms of conscious acceptance and may be considered as sudden shock or cumulative subclinical shock, due to physical violence, chemical insult, or emotional tension.

Dr. McCracken describes the objective symptoms of the above classifications and their treatments.

TRICHOPHYTON RUBRUM INFECTION IN FAMILIES

Mary P. English, *British Medical Journal*, No. 5021, Mar. 30, 1957.

Trichophyton rubrum is the fungus most often isolated from patients with mycotic skin diseases attending the Bristol Royal Hospital. The infection is usually first noticed as a scaling or macerated area between the toes indistinguishable from tinea pedis due to other fungi.

English presents a short review of the literature regarding the incidence of T. rubrum in familial and communal infections. The author reports on the methods, general observations, and the results of a survey in which 32 patients from whom T. rubrum had been isolated and who were living with their families participated.

The evidence indicates that some breakdown in personal immunity (a phase of lowered personal resistance) must precede the onset of clinical disease. Sulzberger and Baer (1955) believe that most supposedly normal persons are carriers of fungi, and that this is the starting-point of clinical disease when immunity breaks down.

It is interesting to note that in the above survey, the nails had been attacked in 78% of all the infected persons. In most of these the disease had begun in the toe-webs, but specialist advice had not been sought at this early stage.

THE TECHNIQUE OF THERAPEUTICS

H. Warmbath, *The Chiropodist*, 8:253-258, Aug. 1957. (London).

This article, by Warmbath, is more in the form of a plea for a review of the existing methods of the application of drugs. One might say, "Why a new drug when the old one is just as good?" It is the feeling of the author that although techniques have been developed in most of the phases of chiropody practice that a corresponding advancement has not been made in the purely pharmaceutical side of our treatment. The author further contends that the profession should compile a new ma-

teria medica and pharmacopoeia for chiropodists, adopting our own standards of preparation and include detailed techniques for application.

Warmbath discusses his views on empirical methods of practice, the development of techniques, diagnosis and observation, and choice of treatment methods. He states that "the passport to efficiency is neatness. It is not what you do but the way that you do it which is the keynote to the technique of therapeutics."

THE TREATMENT OF THE UNSTABLE FOOT

L. C. Gibbard, *The Chiropodist,* 9:287-295. Sept. 1957. (London).

Gibbard states that an unstable foot is one which rolls in and spreads out on weight bearing because it is loosely jointed. Two forms are discussed, namely, the juvenile form and the adult form. The etiology of the unstable foot is classified under fault or failure of structure and failure of function. Under structural faults Gibbard discusses the short first metatarsal, anomalies of the talus, hypermobile joints, and the supinated forefoot. Classified under functional foot faults we find fatigue imbalance of muscles, the sequence of fatigue, and the effects of muscle imbalance (anterior and posterior pronation.)

The treatment of the hypermobile or unstable foot is directed towards relieving strain and restoring correct weight bearing in the foot; reestablishing proper muscle balance; and finally restoring the natural function of the foot and leg. Gibbard tends to accomplish the above thru the use of corrective insoles (appliances) and shoe wedging.

BOOK REVIEWS

APPLIED FOOT ROENTGENOLOGY

Felton O. Gamble, D.S.C., F.A.S.C.R., President, National Association of Chiropodists. Formerly Professor of Roentgenology, Temple University, School of Chiropody. Past President and Fellow, American Society of Chiropodical Roentgenology. Honorary Fellow, American Academy of Chiropody. Cloth. $15. Pp. 414, with 411 illustrations. Williams & Wilkins Co. Baltimore. 1957.

In every era of medicine, certain select texts and treatises have profoundly influenced medical education and practice. So may it be in the chiropodic-roentgenological field. An outstanding example of such a text is "Applied Foot Roentgenology." At the risk of being trite, this work by a distinguished chiropodist can only be called "monumental."

Owing to rapid advances made in the field of roentgenology, there has been real need for the work on the roentgen study of patho-anatomic foot problems. This has been eminently accomplished in the present text. The book is timely since many men have been using X-ray for foot conditions with so little knowledge of the evaluation of patho-anatomical problems.

Applied Foot Roentgenology is the culmination of over twenty years of experience in which Dr. Gamble has endeavored to relate the patho-anatomic patterns to clinical problems. The approach to foot problems is new, relating to specific faults rather than to such generalities as "fallen arches." The book is divided into 2 sections, the first containing 12 chapters and the second part containing 8 chapters. The chapters in the first section develop a phase of interpretation. Part by part the foot is inspected and the various foot types and problems analyzed. These chapters contain such information as the Orthopedic Status of the Foot; Characteristic Structural Pat-

terns of the Foot; Acquired Fault Syndromes; Congenital Pes Planus; Pes Cavus; Pes Adductus; Metatarsal Disorders; Orthodigita Problems; Bone Anomalies; and Podo-pediatric Roentgenology.

The second section of the text deals with Roentgenology Office Practice and considers such topics as Roentgen Equipment for Foot Examination; Radiographic Technique; Evaluation of Foot Radiographs; and Roentgenographic Clinical Applications.

The appearance of the book is most attractive. The paper is of excellent quality, the large print agreeable to the eye, and the illustrations of the highest quality. The facsimile reproductions of the radiographs with their black backgrounds and bones in white have been excellently printed. This is indeed a scientific text which is the result of careful research and planning and is highly recommended as a reference and textbook to all doctors. This book will serve to crystallize thinking in this field and present new facts and stimulating ideas.

Robert Shor, D.S.C.

"MUSCLE TESTING" Techniques of Manual Examination

By Lucille Daniels, M.A., Associate Professor and Director of Physical Therapy Dept. of Allied Medical Sciences, School of Medicine, Stanford University; Marion Williams, Ph.D., Assistant Professor of Physical Therapy, Stanford University; Catherine Worthingham, Ph.D., Director of Professional Education, The National Foundation for Infantile Paralysis, Inc. Second Edition, $4.00, paper cover, 176 pp, 8x10x3/4, 346 illustrations, Publishers, W. B. Saunders, 218 W. Washington Square, Philadelphia 5, Pa.

This new second edition opens up a whole new and practical approach to muscle testing procedures and the functional significance of muscle weakness and contracture. The text endeavors to standardize manual muscle tests and offers tables of figures giving degrees of possible range of motion for all muscles and groupings of muscles.

The illustrations and line drawings are excellent. All muscles are described, giving their origin, insertion and function and nerve supply. The text incorporates the clinical application of more physiologic principles relative to the response of the neuro-muscular mechanism than any previous method of testing.

Carefully organized in 176 pages and with 346 illustrations, this new book shows you in step by step detail just how to carry out the required tests, how to evaluate and diagnose muscular and skeletal weakness. Many dramatic action diagrams make crystal clear the descriptions of all the basic patterns of facilitation, their respective components of motion and major muscle components.

All practitioners concerned with physical therapy, orthopedics or physical education will find this new second edition a practical guide to rational muscle testing and therapeutics. Certain tests for muscles of the extremities have been regrouped with greater clarity. Although Muscle Testing has no index, it does have an excellent bibliography.

The reviewer knows of no comparable work dealing with the examiners' technic in the physical diagnosis of muscle testing, and recommends this book without reservations.

Jack Ranzer, Pod.D.

"Never be haughty to the humble, never be humble to the haughty."

Jefferson Davis

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library at a cost of fifty cents for five consecutive pages.

ANESTHETICS; ANALGESIA

Local Anesthetic Reaction, M. H. Harmel. New York State Jour. Med. 56: 2561-62, 1956.

Reactions to drugs arise either from overdosage or to an idiosyncrasy. Following an overdose the patient may develop convulsions, coma, and then die. Cardiovascular collapse usually follows the coma. Small doses in idiosyncrasies may produce collapse and convulsion and usually lead to death. In the case reported, x-ray examination showed distention in the proximate part of the colon; a barium enema study showed obstruction in the lower part of the descending colon which was diagnosed as a possible carcinoma. Cecostomy was performed under spinal anesthesia. Following decompression the patient was prepared for hemicolectomy. After intravenous injection of 2% glucose, Xylocaine 15 cm. (following a test dose of 5 cc.) was injected into the epidural space. The patient immediately went into convulsions and became unconscious. Convulsions ceased after administration of oxygen and injection of 175 mg. pentothal. The operation was continued after administration of nitrous oxide 75%, oxygen 25%, then 6 mg. d-tubocuraine and later, 18 mg. curare. Postoperative recovery was uneventful. When large doses of Xylocaine are given, it is well to use adrenalin (1:200,000 to 1:500,000) as a vasoconstrictor to prevent rapid absorption and consequent overdosage. For successful treatment of local anesthetic reactions, available oxygen by mask, intravenous barbiturates and vasopressure are required.

CIRCULATORY SYSTEM

Transmetatarsal Amputation in Peripheral Vascular Disease, H. E. Pedersen and A. J. Day. J. Michigan M. Soc. 55: 305-08, 1956.

Transmetatarsal amputation in properly selected patients can result in a well functioning extremity, with relief of symptoms. It often prevents a disabling amputation at a higher level. Gangrene and infection in the toes tend to spread to the dorsum of the foot or along the plantar aspect of the foot, so that amputation is required. Therefore, in selected patients, if gangrene is limited to the toes, removal of the toes is a therapeutic and a prophylactic measure. Selected patients are those in whom infection and gangrene are stabilized in the toes without involvement of the dorsal and plantar surfaces, and those having stabilized open infection in the distal portion of the foot if the entire lesion can be excised and primary closure obtained. The better the circulatory and nutritional status of the foot, the greater chance there is of success. Absence of palpable pulsation below the iliac or femoral artery is no contraindication to the operation. Preoperatively the patient is restricted to bed rest with the extremity flat on the bed and the head of the bed elevated a few inches, to control the infection, to decrease circulatory requirements, and to prevent trauma. Antibiotics are given. Loose sterile dressings are worn, but removed once or twice a day for a 15-minute foot bath in tepid water and white soap. Necrotic tissue spontaneously separated in the footbath should be removed. Amputa-

tion is postponed until the infection is completely controlled and no progression of gangrene is evident. The operation was used in 33 amputations on 30 patients with peripheral vascular disease. One-third had primary healing; one-half had secondary; two patients have small granulating areas which are expected to heal. Delayed healing usually was due to marginal necrosis of wound edges or to wound infection. Lumbar sympathectomy apparently did not affect the final outcome, though some of the good results may have been due in part to increases in peripheral blood supply. In this series of 30 patients only 6 required reamputations. Removal of all toes is recommended as excision of only the involved toes may allow gangrene to develop in the remaining toes, making a major amputation necessary.

The patient and his family should be informed regarding the nature of the disease and that improvement will take time, patience, and cooperation. Good care of the extremities is important: daily foot baths, followed by cautious drying and application of foot powder to lessen chances of fungus infection. Lanolin or some other skin oil is applied if the skin is dry or scaly. Self treatment of corns, callouses or other foot disorders is condemned. Trauma should be avoided. Soft stockings and well fitting shoes reduce the danger of irritation, and keep the feet warm. The body should be protected by warm clothing during cold weather. Rest for several weeks is essential in cases of pain, small ulcers or gangrene. Later, slow walking for short distances will promote collateral circulation. A low fat diet corrects obesity and controls possible damage from excess lipids, but an extremely low fat diet is not recommended. Tobacco and vasoconstricting drugs are contraindicated. Nervous tension and all emotional disturbances are aggravating factors. Alcohol is the best vasodilator but should be used as medicine only. Arlidin seems satisfactory in dilatation of deep muscle arteries. Sympathectomy may be helpful in patients suffering from coldness and superficial ulceration; it does not relieve pain. Physical and mechanical therapy sometimes are helpful: Buerger exercises and massage; use of a light warm blanket wrapped around the extremity and covered with a loose boot to retain body heat is preferable to dry or moist heat which may burn. A heat cradle set at 92 to 96 degrees F. may be placed over the extremity. The oscillating bed is the most helpful device when other measures fail to bring comfort. All associated diseases must be treated. Patients who refuse to stop smoking do not respond to treatment.

Surgical Treatment of Lymphedema, W. T. Swartz. J. Kentucky Med. Assn. 54: 590-94, 1956.

Lymphedema follows invasion of the lymphatic system of the extremities by the filarial worm, by Mycobacterium tuberculosis, and by the Trepinema pallidum. Infective lymphedema is also caused by secondary invasion of streptococci. Other causes are malignant tumors obstructing lymph channels, occlusion of a major vein in an extremity, or secondary lymphatic inflammation following milk leg. Treatment consists of correction of the underlying cause. A case is reported of massive lymphedema following a gunshot wound of the thigh which caused an elephantine process to develop six months later. The Kondoleon procedure performed 19, and again 21, years later proved unsuccessful. Radical excision of all involved tissue in a single piece down to the muscle bellies was then done. Split thickness skin grafts from the abdomen and the opposite thigh were applied; antibiotic was given for 10 days preoperatively. Seventeen months later there was no swelling and the extremity was functioning well. Calf measurements correspond to those of the other side.

Treatment of Superficial Thrombophlebitis, J. J. Gertner. J. Amer. Geriatrics Soc. 4: 823, 1956.

Twenty cases of superficial thrombophlebitis were successfully treated by injection of hydrocortisone acetate suspension (25 mg. per cc.). Injections of 0.5 cc. hydrocortisone suspension and 1.0 cc. tetracaine solution were injected directly into the painful indurated area of the thrombotic process. In most cases two injections were required in a few instances. Pain, swelling, and disability were greatly improved; no untoward effects followed.

An Approach to Etiology, Diagnosis and Management of Peripheral Arteriosclerosis, W. E. Jahsman. Henry Ford Hosp. Med. Bull. (Detroit): 4:56-61, 1956.

Arteriosclerosis seems to be a result of the aging process occurring in the arterial wall, with establishment of a substrate for penetration and accumulation of cholesterol from disturbance in lipid metabolism. Although occurring in all humans living long enough, symptoms occur only in those who fail to develop adequate collateral circulation to compensate for occlusion of the affected vessels. It is easily diagnosed since no other disease causes calf-muscular pain in one or both legs during walking, or other leg strain, and disappears with rest. Such a pain in hip or thigh muscles with or without leg muscle pain, arouses suspicion of segmental occlusion of the large arteries (femoral or iliac) with or without more distal occlusive arterial disease. Elevation of the leg causing increased blanching and redness or bluish discoloration during dependency indicates insufficiency of a leg artery. X-ray examination showing calcification of blood vessels excludes thromboangiitis obliterans, but there is no direct relationship between the degree of calcification, or its absence, with the intensity of symptoms, nor is it related to age. The disease can be controlled, not cured.

Chronic Leg Ulcers, G. K. Hewitt. Physiotherapy 42: 43-45, 1956.

Treatment of leg ulcers requires, first of all, cooperation between patient and doctor. The patient must recognize that a combination of rest, graduated exercise in elevation and ambulant compression must be carried out, and, further, that outside application of ointments is of little value. Should infection occur, antiseptic applications are helpful for a short time. Application of a stimulating, sterilizing massive dose of ultraviolet light is valuable in the early, "dirty" stage. General health measures must be followed. Since obese persons tend to have ulcers, patients must have the will to reduce. Any underlying anemia and vitamin deficiency must be treated. Home treatment includes keeping the feet clean, walking about and avoiding standing or sitting with the legs down for long periods; lying on a bed with the legs raised, foot and leg exercises and leg rolling should be done as often as possible every day. The foot of the bed should be elevated at night. Elastic bandages should be removed when going to bed and reapplied on arising; other bandages should be left on. The leg should be redressed twice a week at home. Various types of physiotherapy are helpful, such as the Bisgaard treatment, chlorophyll and hyalase ionization, massage and exercises, special baths, and ultraviolet treatments.

Surgical Management of Ulcerative (Stasis) Disease of the Lower Extremities, I. Norwich. So. African M. J. 30: 426-29, 1956.

Both primary and secondary varicose veins, complicated by venous stasis disease, produce severe changes in the skin of the distal parts of the lower extremity. Invari-

ably there is a tendency to swell and to produce incompetent varicose veins and the attending crippling disabilities of ulceration, eczema and indurated cellulitis, usually in the medical and lateral aspects of the distal third of the leg. Venous stasis together with increased vein-pressure causes the characteristic edema. Superficial varicosities secondary to deep vein disease are incompetent and aggravate the venous stasis. These secondary veins are not the only channels for the return of venous blood from the lower extremities as generally believed; they therefore should be ablated.

Satisfactory and long lasting cures in many cases follow radical, efficient removal of the varicosities, blow-outs and feeder veins from the affected skin areas. Surgical therapy should include removal of all the damaged skin and subcutaneous tissue, with the underlying fascia, the long and lesser saphenous systems, and the local perforators and feeder veins. A series of 1,000 cases of primary and secondary varicosities were operated on during a 10-year period, including 200 phlebectomies performed on patients with previous deep-vein involvement who showed signs of the typical post-phlebitic syndrome. In these cases 30 skin grafts were combined with phlebectomy; 22 of the skin grafts were successful. The surgical treatment consisted of a radical phlebectomy of the long and lesser saphenous cysts together with excision of the secondary branches, perforators and feeder veins. Eradication of all superficial varicosities will not remove the pathologic process causing edema. When edema persists it may be controlled by use of elastic stockings, elastic bandages, or both, which must cover the heel, leg and lower thigh. Ulcers resulting from primary varicose veins usually heal following eradication of these veins alone. The patient should be instructed in proper care of the feet and legs, use of supportive bandages, and not to stand too long, and to take a 2-hour rest period each day if possible. He should always keep the foot of the bed raised 6 to 9 inches.

DERMATOLOGY, ALLERGY AND FUNGUS DISEASES

Contact Dermatitis Due to the Acrylic Materials Used in Artificial Nails, O. Canizares. Arch. Dermat. 74: 141-43, 1956.

A manicurist who applied artificial plastic nails to the fingers of clients frequently came in contact with the mixture, as she held the customer's fingers with her left hand while applying the nails. A dermatitis developed on some of the fingers and on the thumb of that hand, and spread to the hand, wrist and forearm. She wrapped tinfoil around her fingers and wore rubber gloves, but the eruption increased and she had to stop working. She improved after topical applications and use of superficial grenz ray therapy. The sensitizing agent was found to be the liquid monomer methylmethacrylate.

Skin Manifestations of Nutritional Deficiencies, R. W. Vilter. Merck Report 65: 14-18, May 1956.

Deficiencies in niacin, riboflavin, and vitamin B_6 lead to seborrhea-like dermatitis. Deficiencies in these three vitamins and also protein and iron deficiencies may cause cheilosis and angular stomatitis. Pellagra and kwashiorkor (protein deficiency) can produce severe anascara, acrocyanosis of the feet and hands, and abdominal distention. The latter disease is distinguished from pellagra by the skin peeling off in large sheets. Vitamin A and vitamin C deficiencies produce skin lesions resembling keratitis rubra pilaris. Brittle and deformed nails result from kwashiorkor, iron and vitamin A deficiencies. Aminopterin and amethopterin used in treatment of leukemia may produce a

maculopapular erythematous rash, loss of hair and ulceration of the mouth. A careful medical and dietary examination is necessary in addition to thorough physical examination to determine the cause of a skin lesion.

A Clinicopathologic Study of Fifty Cases of "Connective Tissue Disease," W. M. Mikkelsen, H. A. Zevely, et al. Univ. Michigan M. Bull. 22: 127-55, 1956.

The experiences at this hospital with disseminated lupus erythematosus, polyarthritis nodosa, dermatomyositis, and diffused scleroderma are reviewed; the diagnosis was confirmed in all cases at necropsy. Disseminated lupus erythematous, a systemic disease has a poor diagnosis since most recognized cases have been fatal. Of 21 patients (only 9 were male) in patients 11 to 60, 10 had insidious onset; 6 were acute and progressed rapidly; the others were subacute or intermittently active. Duration of the disease was from 5 months to 10 years. Of 18 patients with polyarthritis nodosa 12 were male, with symptoms for 5 months to 5 years (average 15 months). Musculoskeletal, gastrointestinal and neurologic symptoms were present in 14 patients, genito-urinary in 13, cardiovascular in 11, cutaneous in 11 and pulmonary symptoms in 9 patients. Dermatomyositis occurred in 5 patients, aged less than 10 years to 60 years. These patients all had cutaneous manifestations and musculoskeletal symptoms, 4 had cardiac, 3 gastrointestinal, and 4 pulmonary symptoms. In one instance there was an associated carcinoma. Six patients with diffuse scleroderma (average age 40 years) had joint symptoms, most common in the fingers, wrists, elbows and knees, and to a less degree in the shoulders, hips and ankles. Joint movements were limited in areas having cutaneous involvement. Musculoskeletal and cutaneous symptoms occurred in all, gastrointestinal, pulmonary and renal symptoms in 2 and cardiac symptoms in 3 patients.

DRUG THERAPY

Topical Use of Amphomycin and Amphomycin-Neomycin Ointments, G. A. Cronk and D. E. Naumann. Antibiotic Med. 3: 142-45, 1956.

Calcium amphomycin ointment with or without neomycin added (5 mg./Gm. each) proved to be an effective antibacterial agent in such dermatologic conditions as impetigo, where the antibiotic reaches the bacteria. It failed in treatment of acne vulgaris. No skin sensitization nor irritation followed use of the ointments. The simple nutrient broth media used in testing bacteria sensitivity to amphomycin requires a concentration two hundred times greater than when a more complex media is used to inhibit susceptible bacteria.

I. Dangers of Self-Medication with Cortisone and of Neglect of the Signs of Acute Adrenocortical Insufficiency. II. Value of Local Treatment of Arthritis and Related Conditions by Injections of Hydro-Cortisone Acetate, A. Rytel. Acta Med. Scand. Supp. 312: 474-76, 1956.

Three cases are described in which the patients took cortisone tablets without prescriptions, for treatment of arthritis or joint pains. A man operated on for incarcerated ventral hernia died two days later; autopsy findings showed absence of the cortex on one adrenal and almost no cortex on the other. A girl died within a day following an operation for acute appendicitis; no autopsy was obtained but death was believed due to cortisone which she had been taking, 75 to 100 mg. daily. A third patient after operation for perforated peptic ulcer had a difficult recovery. He too had been taking cortisone without its being prescribed.

Only carefully selected patients are qualified for cortisone therapy and they must be

watched for hyperfunctioning of the adrenal cortex (moon face, buffalo hump, acne, hypertrichosis, fluid retention, loss of calcium, phosphorus and nitrogen; hemorrhagic phenomena of the skin, sexual disturbances, thrombophlebitis, psychoses). Local intra-articular therapy of arthritis and related conditions should be instituted with saline suspension of hydrocortisone acetate (compound F acetate — 17-hydrocortisone-21) in cases with localized changes, when contraindications to systemic treatment exist or complications are noted, to avoid hyperadrenocorticisme. In treatment of large groups of patients having rheumatoid arthritis, tolerance was good to local injections of hydrocortisone acetate 25 mg. to 50 mg. into large joints and 5 mg. to 20 mg. into small joints. Improvement was reported in 85 per cent to 92 per cent of the patients.

MEDICAL PRACTICE; REHABILITATION

Rehabilitation of the Aged, T. E. Hunt. Canad. J. Occupat. Ther. 23: 64-69, 1956.

Many aged patients obviously ill and handicapped by disease (heart disease, stroke, arthritis, severe fracture, cancer) can be rehabilitated, and changed from a bedridden handicapped individual to a person sitting in a wheelchair or using crutches, and attending to hygienic needs. Patients severely senile and disturbed may through a rehabilitation program attain improvement in general status and require much less care and a great reduction in soiling and in incontinence. Clothing them and getting them to sit beside the bed, or to walk a few steps, even getting to the bathroom unassisted or going there by wheelchair is of great help to those caring for them. Handrails on the bed and along the walls and beside the tub and toilet are helpful. Floors should not be slippery. The old person who is not ill nor senile but showing the effects of aging should not be allowed to fold up because of a feeling of loneliness, uselessness and unwantedness. Forced retirement laws at 60 to 65 of a perfectly healthy person should be revised and retirement put on a voluntary basis. Gradual diminishing of weekly hours and strenuous labor would provide a measure of security and a feeling of usefulness. Older persons should have some form of occupation: part-time work, a business of their own, or something entirely new. Some social obligation in church or voluntary health organization where their wisdom and experience would be of value will make them happier. They should be allowed to share in running the home or to do some craft work; this can help them to maintain their self esteem.

MUSCULOSKELETAL SYSTEM

Recovery of Power in Leg Muscles Following Poliomyelitis, R. Palmer and C. D. Martz. Phys. Ther. Rev. 36: 466-73, 1956.

An analysis was made of 997 individual muscles which move the foot, in 130 cases of poliomyelitis. Some patients who had been confined in respirators did not have muscles analyzed adequately for classification until two months after the attack and therefore two months was the period selected as the basic time. Muscles testing "out" after paralysis for two months were classified base O; base T designated those testing "trace"; base P for those testing "poor"; base F for "fair"; base G for "good"; base N for "normal." Muscles testing base O or T give a poor diagnosis; G to N muscles do well. The prognosis is less reliable in base F groups. Where corrective surgery is considered, 12 months after onset seems to allow a sufficient margin of safety to exclude the possibility of late recovery. Muscle transfers to increase the power of muscles weakened by poliomyelitis and to remove a deforming force were performed in the cases studied. It was found that after transference of its insertion, a muscle will probably lose one or two

grades of power, and this should be considered when surgery to correct weakness or imbalance is contemplated. Various types of tests are considered; the manual testing method seems the best now available.

X-RAY

A Masking Technic for Photographic Reproduction of Roentgenograms, T. W. Strauss and A. S. Tucker. Cleveland Clin. Quart. 23: 139-52, 1956.

A simple inexpensive, positive masking technique is described for improvement of photographic reproduction of roentgenograms, particularly those with a great range of contrast; it is even more effective in making transparencies or lantern slides. A very light positive film is used as the mask. A small-sized negative of the roentgenogram is made, the negative when dry placed emulsion side down on the contact printer and a sheet of unexposed film placed emulsion side down on the negative. The second film is exposed and processed in the usual way. A positive negative results with densities homologous to those of the roentgenograms. The improvement is due to the quite uniform deposit of silver covering the edges of the fine details in the mask. Diagrams of the process are given.

MISCELLANEOUS

The Growing Influence of Hospital Accreditation, C. U. Letourneau and D. Boehm. Hosp. Manag. 82: 48, Oct. 1956.

In its 35 years of existence accreditation has been a chief cause of much of the improvement in modern hospitals. A physician associated with a non-accredited hospital gains no prestige. A hospital is not accredited if it has on its staff medical graduates from a non-approved school, or not eligible to membership in the County Medical Society, or if its staff performs substandard work, particularly surgery. Fee splitting and other unethical practices prevent accreditation. The "Essentials" for approval for teaching programs for doctors in training require accredited hospitals. Doctors desiring certification in a specialty must serve a certain number of years in educational programs approved by the A.M.A. in accredited hospitals. Serving time in a non-accredited hospital after graduation is not credited. Members of associated professions—nursing, physical therapy, pharmacy and social service—may be attracted to non-accredited hospitals by higher salaries and greater prerequisites, but usually prefer accredited hospitals. Hospitals with nursing educational programs with accreditation are more successful in recruitment of students than the non-accredited. A non-accredited hospital has difficulty securing a good professional administrator. A hospital administrator for eligibility to membership in the American College of Hospital Administrators must be in an approved hospital, unless the Credentials Committee uses discretion in relation to an administrator.

Planning Your Office, (Pt. III), M. K. Mills. J. Iowa State Med. Soc. 46: 515, 613, 1956.

The size and position of an adequate x-ray room is described; for the average x-ray equipment 4 ft. x 5 ft. is adequate, with a separate dressing-room if possible, or else provision of a curtain that can be drawn to seclude a corner of the room. The laboratory space and necessary plumbing and its location are discussed, and the required space for heating, air-conditioning, and closet storage space. Hall should be no longer or wider than necessary; besides providing connection to the reception room and business office, they should provide a separate entrance for the doctor and possibly egress for the patient. A sample floor plan for the solo practitioner's suite is sketched.

The Impact of Nuclear Science on Medicine, L. E. Farr. Science in Progress ser. 9: 161-80, 1956.

In administering radioactive isotopes internally to patients, it is important to note the effects of the radioactive element on the blood-forming organs, since too large a dose of I^{131} can cause fatal aplastic anemia; a maximal dose must be determined which affords the greatest possible disease control with minimal hazard. In evaluating hazards to the blood and kidneys, physiologic effects must also be considered, such as the effect of radiation on immunity mechanisms — the capacity of the body to resist invasion of bacteria, viruses and parasites. Studies have been made to determine the effect of radiation on susceptibility of animals to infection, and the effects of radiation upon antitoxic immunity; also studies of amino acid physiology beginning with disposition of the amino acids throughout the body — how these free amino acids in the blood are transported to the various cells of the body where they are used, and the period of time required after a specific amino acid enters a cell before metabolism or synthesis takes place. The various pools of amino acids in the body give a picture of the relationship existing between the particular organ and the available tissues to be analyzed. A study of the plasma amino acids aids in predicting the happenings in any of these, together with such observations of metabolism as measured by CO_2 elimination. As factors affecting transportation and distribution are understood, it is possible to accurately observe the mutation of amino acids over a very short period of time. The analytical data obtained should state whether amino acid metabolism is normal or abnormal, and if the latter, which organ or system is involved.

That stable elements can capture slow or thermal neutrons, thereby becoming unstable and developing radioactivity, has long been known. With use of a nuclear reactor it is possible to explore the possibilities of such a capture reaction for medical therapy. In humans neutron exposure can be kept below ordinary hazards for normal tissues, but by capture it is possible to provide significant radiation to tumors. But it is necessary to know the exact time-concentration relationships of a capture element within the segment of the body exposed to neutrons. Such observations were made on the distribution of radioactive sodium in patients with edema and accumulations of fluid in the body cavities, which provided opportunities to develop a tracer theory as applied to specific systems. Further studies are being made regarding distribution of radioactive sodium in various body compartments and the development of mathematical expressions of the behavior of the particular substance with regard to its movement from one body compartment to another. It should be possible to give an effective, highly selective radiation dose to the brain tumor by knowledge of the physiological behavior of a given element in relation to the brain itself, rather than by virtue of a specific affinity of this element for the brain tumor. This is a better approach than exploring innumerable compounds to find one with the desired tumor tissue affinity; this also can be applied to any area of the body. Thus, application of isotopes and study of kinetics of equilibria of the physiologic systems of the body should be placed on an exact mathematical formulation, if these new tools are to be profitably used.

"If I rest, I rust."

Martin Luther

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

CALIFORNIA

The Southern California Association of Chiropodists will hold its 7th annual seminar, Saturday and Sunday, February 8th and 9th, 1958, in the Assembly Room of the Statler Hotel, Los Angeles, California. Dr. Ralph E. Fowler of Detroit, Michigan, will lecture both days on "Complete Foot Surgery Care" and "Foot Surgery Economics." Dr. W. Cartledge is Chairman, Drs. Turchin, Silver and DeLeo are Co-Chairmen.

COLORADO

The Colorado Association of Chiropodists have instituted a new practice to honor outgoing Presidents. At future annual meetings the outgoing President will be given a plaque inscribed with his name, the name of the association and the year served. A testimonial dinner was held recently and plaques were awarded to all Past Presidents who are active members of the association. The plaques were awarded as follows: Drs. Etta B. Watson, Nathan Wallace, C. A. Fritts, Norman Tripp, Harry Halton, George Helbig, Robert Walker, Roy Oberling, Kenneth Edwards, Jr., Charles Lorett, George Patton and Stanley Rheaume. Mrs. Lily Riepen was awarded the plaque of Dr. Harold Riepen who served from 1952-53.

The first Honorary Membership to be granted by the Colorado Association was bestowed on James Rae Arneill, M.D., a prominent surgeon, for his interest, cooperation and friendship to the members of our association and to our profession.

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

WOMEN'S AUXILIARY
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Please ship to me "Life's Foundation — Your Baby's Feet" in the quantity marked:

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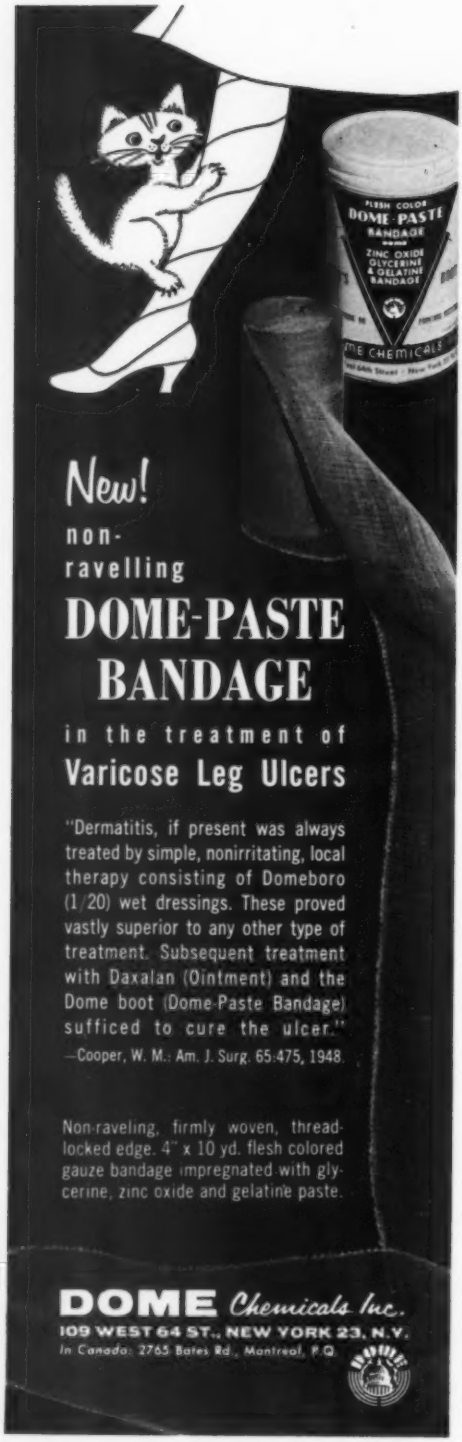
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—Cooper, W. M.: Am. J. Surg. 65:475, 1948.
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DELAWARE

Dr. Harold Orr was elected president of the Delaware Chiropody Society at its recent annual meeting in the Academy of Medicine.

Other officers elected were: Dr. Harold Friedman, vice president; Dr. Edward Schlanger, secretary; Dr. John Sowinski, treasurer.

The principal speaker was Dr. Lawrence Silverman, who gave a demonstration of making casts for the fitting of contour shoes.

IOWA

At the annual meeting of the Iowa State Chiropody Association held in Des Moines on December 7 and 8, the following officers were elected: President, Dr. G. L. Smith, Waterloo, Iowa; President-Elect, Dr. W. L. Franson, Perry, Iowa; 1st Vice President, Dr. R. M. Henery, Des Moines, Iowa; 2nd Vice President, Dr. C. A. Bartell, Dubuque, Iowa; Secretary-Treasurer, Dr. D. K. LeDuc, Council Bluffs, Iowa; Region Six Delegate, Dr. E. S. Thompson, Davenport, Iowa; A.P.A. Delegate, Dr. C. T. Howard, Boone, Iowa.

Scientific sessions included a lecture on "Surgery of the Forefoot" by Webster B. Gelman, M.D., of the Arthur Steindler Orthopedic Clinic in Iowa City, Iowa. Also appearing on the program was Dr. R. R. Schivley of Fort Madison, Iowa, who gave a demonstration and explanation of a special shoe for the difficult foot. He was assisted by Mr. A. F. Becker, Superintendent of the Shoe Division at Iowa State Prison, where the custom-built shoe is being developed.

NEW YORK

Dr. Irving L. Marks, President, and Dr. Benjamin C. Mullens, Public Relations Director for the Podiatry Society of the State of New York, announce that a number of new public relations pamphlets will be issued by the Podiatry Society. These were

prepared under the direction of Mr. Gilbert Hollander, Executive Secretary of the Podiatry Society, in cooperation with a leading firm in the field of health literature.

Mr. Hollander described this as a coordinated, fully rounded foot health kit, as opposed to the single pieces of literature which have been used previously. He stated that this was a preferable method in good public relations practice since the impact of a total program would give impetus to any foot health project in the public interest. The pamphlet kit consists of the following:

Four individual brochures on the most important phases of foot care.

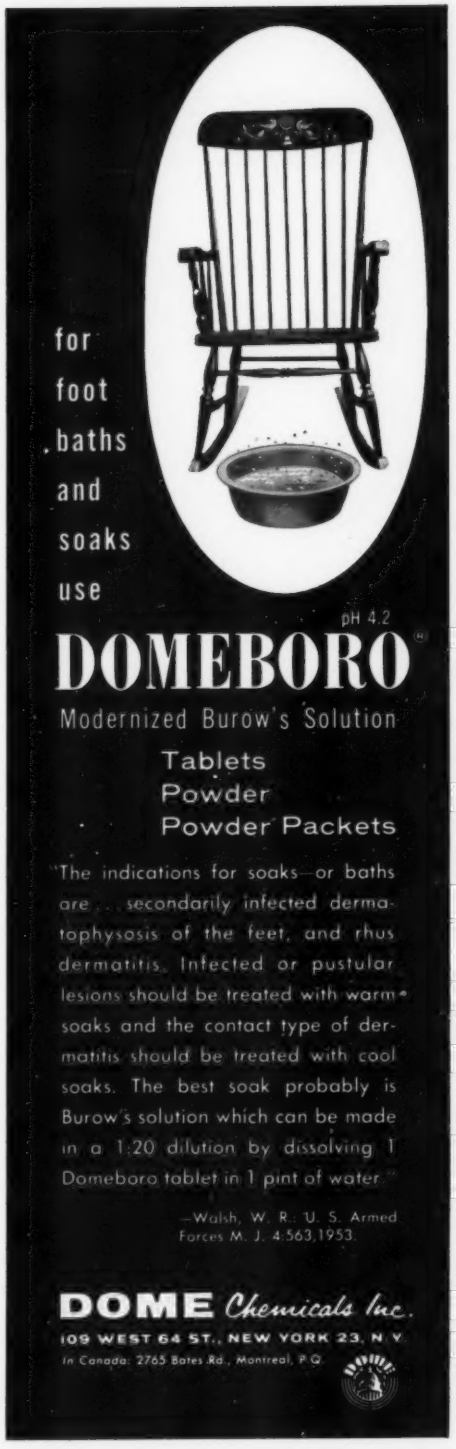
1—Foot Health for Children.
2—Foot Health for Diabetics.
3—Middle Aged Feet.
4—General Foot Health.

These will be available for general public distribution.

In addition, a much larger booklet entitled "AN EVALUATION OF FOOT CARE IN NEW YORK STATE" has been issued as a public service. This will be made available to insurance company libraries, newspaper editors, legislators, advertising and public relations agencies, executives, educational institutions and various other opinion molders in the community. This brochure poses in a lucid, concise manner, the public health problems inherent in foot disability and the facilities and services for foot care that have been developed in New York State in recent years.

All texts are replete with authoritative foot health information and the art work, while in a light vein, is particularly apt and essentially educational. Based on the opinions of a number of public relations experts to whom the brochures were submitted, Dr. Marks and Dr. Mullens concluded that these are amongst the most outstanding brochures ever issued for the profession of podiatry.

These pamphlets will be part of a public information kit which will be distributed to all those attending the coming Foot Care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—Walsh, W. R.: U. S. Armed Forces M. J. 4:563,1953.
DOME Chemicals Inc.
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In Canada: 2765 Bates Rd., Montreal, P.Q.

Conference of the Podiatry Society over the Washington's Birthday weekend this coming February in New York City.

Copies may be secured by attending the Foot Care Conference or having your State Secretary write to Mr. Gilbert Hollander, Executive Secretary of the Podiatry Society of the State of New York.

OKLAHOMA

The Oklahoma Chiropody Association held its semi-annual Post Graduate meeting in Oklahoma City, November 2 and 3, 1957. Dr. Ralph Fowler, the main speaker, pointed out the "Type of Success that can be Obtained in Chiropody." He also spoke on Chiropodial Surgery; Dr. Lafe Midkiff presented a film on Tolserol and its uses for the chiropody profession; Dr. Ralph Owens lectured on the uses of Contura-Presstoplast in the treatment of ankle sprains and the easiest way to adjust metal braces; "The Importance of Oxygen in the Chiropody Office," was the subject of Dr. Earl Weibel. He demonstrated a portable unit which is available at a modest cost, Dr. C. Parham gave a discussion on appliances which can be made in the office, such as exercise skates and a rocking horse type apparatus to stretch calf and other leg muscles; Dr. Leonard Houx and Dr. S. D. Tomlinson discussed "Patient Good Will" and "Examination."

Many chiropodists visited from Arkansas, Kansas and Texas.

PENNSYLVANIA

Chiropody Society of Pennsylvania

The Western Division of the Chiropody Society of Pennsylvania met in the Hotel Webster Hall, Thursday, November 14, 1957. Milton Golumb, M.D., lectured on "The Gouty Foot, as the Chiropodist Sees It."

The Annual Science Seminar Chiropody O'Rama of Western Division was held in the Hotel Webster Hall on Sunday, November 17th. The Post Graduate course was well attended by men from Western Pennsylvania, Ohio and West Virginia. Speakers

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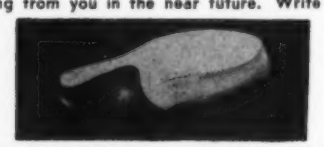

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were: B. C. Egerter, D.S.C., "The Dye Technique"; Jerry Miller, D.S.C., "Contour Shoe Casting"; R. W. Goldblum, M.D., "Diseases of the Nails"; H. H. Haber, D.S.C., "Painful Heels," and C. D. Bossart, D.S.C., "Metatarsus Varus."

Members of the Women's Auxiliary met for professional counseling on personal make-up and the demonstration of fancy party snacks.

Philadelphia Chiropody Society

The monthly scientific meeting of the Philadelphia Chiropody Society was held on Tuesday, November 19, 1957 at the Philadelphia County Medical Society Building. Dr. Alan Pasternack, program chairman, presented Rubin Rosen, D.S.C., who demonstrated Levy Mould casting technique plus fabrication of a custom molded sandal.

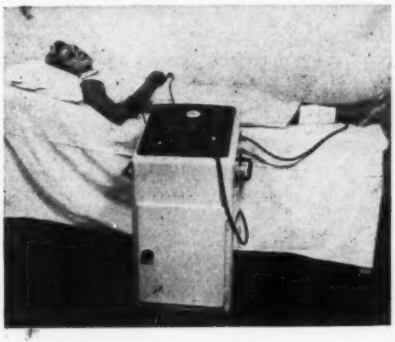
Presiding over the meeting were Dr. Martin Horwitz, President, and Dr. Alvin M. Nissenbaum, Secretary.

ILLINOIS COLLEGE OF CHIROPODY AND FOOT SURGERY

The Illinois College of Chiropody and Foot Surgery announces the 25th reunion and homecoming of the Class of 1933. This is the first time such a 25th reunion has been attempted and it is hoped that all will avail themselves of this opportunity to renew old acquaintances and visit their Alma Mater. Commencement exercises for the Class of 1958 will be held on Saturday, May 24, at 4 p.m. A banquet is being held on Saturday at 7 p.m. at the Hotel Maryland, 900 N. Rush Street, Chicago, Ill. For information, write to Dr. Milton R. Lewis, 3910 Diversey Blvd., Chicago 47, Illinois.

It took me fifteen years to discover that I had no talent for writing, but I couldn't give it up because I was too famous.

Robert Benchley



PROVED: An Electronic Mechanical Method for Treating Peripheral Vascular Diseases

Reports by Lyons, Meadows and Fuchs* indicate a vast improvement in circulatory disturbances by stimulation of the peripheral circulation with this new, more physiologic, electronic, mechanical device.

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The treatment is followed by a remarkably prompt alleviation of pain, improvement in walking capacity, relief of intermittent claudication, and the healing of ulcers and gangrene.

* Lyons, Meadows, and Fuchs. A New Method for the treatment of Peripheral Vascular Disease. Southern Medical Journal, Volume 48, Nov. 8, Aug. 1955, Pages 811-819.

For Information, Write

SYNCARDON CORPORATION OF AMERICA

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PRESIDENT MORRIS RECEIVES AWARD

Presentation of Award for outstanding services to the profession of Chiropody to Dr. Jonas C. Morris, Audubon, N. J., President of the American Podiatry Association, by Dr. Clarence Bookbinder, Burlington, N. J., President of the New Jersey Chiropodists Society, at a Testimonial Dinner tendered Dr. Morris at Cherry Hill Inn, Haddonfield, N. J., by the New Jersey Chiropodists Society, Nov. 30th, 1957.

Left to right: Dr. B. C. Egerter, Pittsburgh, Pa., President of the Ohio College of Chiropody; Dr. Clarence Bookbinder, Burlington, N. J., President, New Jersey Chiropodists Society; Dr. Jonas C. Morris, Audubon, N. J., President National Association of Chiropodists; Dr. Jack Horwitz, Burlington, N. J., Secretary of the New Jersey Chiropodists Society; Dr. George Deyo, Elizabeth, N. J., Toastmaster.

ACCREDITED COLLEGES

California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

Chicago College of Chiropody
1422 W. Monroe Street
Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.

THE AMERICAN FOOT HEALTH FOUNDATION

Have you sent in your membership dues for 1958 to The American Foot Health Foundation? The AFHF wishes to place in your hands the report that Dr. Fischman, in the following letter, found so stimulating.

The Board of Trustees
American Foot Health Foundation
3301 16th St., N. W.
Washington 10, D. C.

Gentlemen:

I have enjoyed reading the 24-page Annual Report of The American Foot Health Foundation sent to me as a member and I am deeply impressed with the work already done and the excellent plans projected through 1958.

I was particularly interested in the immense possibilities for research services to industry, pharmaceuticals, footgear manufacturers, etc., as explained in the section of grants-in-aid. I had no idea that so much already had been accomplished along this line. I am also pleased to see that the opportunities present for securing financing of the foundation's activities in national foot health surveys and other support from philanthropic, public welfare, health and educational foundations represent a vital part of the program.

After reading this impressive report I am convinced that the Foundation must have administrative money to continue these activities. This is obviously a responsibility of the chiropodist-podiatrist. To me it is a privilege, and I am more than willing to pay my annual membership dues of ten dollars, which I consider a mere pittance in view of the broad scope of the public relations program for the benefit of our profession.

I am sure that if all practitioners will become annual members, that, in the aggregate, the sum secured will enable the Foundation to fulfill its entire program, so thoroughly presented in the report which you are sending to each member.

My congratulations on the fine work.

Sincerely,
(Signed)
Daniel H. Fischman, Pod.D.
6915 Grand Avenue
Maspeth 78, L. I., N. Y.

You will receive your copy of this report when you send in your annual dues of a nominal ten dollars to The American Foot Health Foundation, 3301 16th St., N. W., Washington 10, D. C.

Dr. Sidney Hirschberg, President
Board of Trustees
The American Foot Health Foundation

Butler's Chiropody Supply Co. announces with profound sorrow the death of

Joharie J. (Joe) Butler
December 4, 1957
San Francisco, California

Business will continue under the same established policies.

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1958 MEMBERSHIP
IN THE
AMERICAN FOOT HEALTH FOUNDATION
NOW BEING ACCEPTED

CONVENTION DATES AND MEETING NOTICES

National Association of Chiropodists
Washington, D. C.
August 22-26, 1958
Shoreham Hotel

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Boston, Mass.
Oct. 17, 18, 19, 1958
Sheraton Plaza Hotel

Region Two
(New York)
New York, N. Y.
Feb. 21-23, 1958
Barbizon Plaza Hotel

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J.
April 17-20, 1958
Ambassador Hotel

Region Four
(Ohio)
Toledo, Ohio
May 17-18, 1958
Commodore Perry Hotel

Region Five
(Ill., Ind., Mich., Wis.)
Chicago, Ill.
March 21, 22, 23, 1958
Morrison Hotel

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Denver, Colorado
April 11-13, 1958
Cosmopolitan Hotel

Region Seven
(Idaho, Mont., Oreg., Wash., Wyo.)
Tacoma, Wash.
April 25, 26, 27, 1958
Hotel Winthrop

Region Eight
(D. C., N. C., S. C., Va., W. Va.)

Region Nine
(Florida)

PHI ALPHA PI

NATIONAL SCIENTIFIC CONVENTION

FEBRUARY 7-8-9, 1958

PHILADELPHIA, PENNSYLVANIA

BENJAMIN FRANKLIN HOTEL

THREE FULL DAYS OF;

—LECTURES BY OUTSTANDING MEN IN THE SCIENTIFIC FIELDS.

—NEW AND INFORMATIVE EXHIBITS

—PLANNED LADIES' PROGRAM

PLAN NOW TO ATTEND

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Dallas, Tex.
June 19-22, 1958
Statler Hilton Hotel

Region Twelve
(Ariz., Cal., Nev., Utah)
Los Angeles, Calif.
May 30-31, 1958
Ambassador Hotel

American College of Foot Orthopedists
2nd Annual Scientific Session
March 20, 1958
Chicago, Ill.
Morrison Hotel

American College of Foot Surgeons
Las Vegas, Nev.
Feb. 17-19, 1958
Riviera Hotel, 1958

North Carolina Chiropody Association
Scientific Conference
Southern Pines, N. C.
Jan. 25, 26, 1958
Hollywood Hotel

Phi Alpha Pi National Fraternity
Philadelphia, Pa.
Feb. 7, 8, 9, 1958
Benjamin Franklin Hotel

Southern California Association of Chiropodists
Los Angeles, Calif.
Feb. 8, 9, 1958
Statler Hotel

American Podiatry Council
New York, N. Y.
Jan. 24, 1958
New York Trade Show Bldg.

American Chiropody Society of Low Voltage Therapeutics
Philadelphia, Pa.
Feb. 15, 16, 1958
Hotel Sylvania

DEATHS REPORTED

Vincent A. Barra
Belleville, N. J.

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APPOINTMENT TO YALE UNIVERSITY

The Executive Committee of the Board of Directors of the Grace-New Haven Community Hospital, on recommendation of the Medical Board of Yale University, appointed Andrew S. Anastasio, Pod.D., Assistant Consultant of the Chiropody Service, Orthopedic Clinic, Yale University Medical School. Dr. Irving Yale, D.S.C., is the Chief Consultant.

APPOINTMENT TO THE UNIVERSITY OF CALIFORNIA

Leo N. Liss, D.S.C., San Francisco, California, has recently received an appointment as Assistant Clinical Professor of Chiropody in the School of Medicine of the University of California Medical Center, San Francisco, Calif.

Dr. Liss has served as Visiting Chiropodist and Consultant Chiropodist in the Outpatient Department of the University of California Medical Center, Diabetic and Peripheral-Vascular Departments for the past sixteen years.

MISSING

Our readers are requested to assist in the tracing of a missing person. She is likely to require foot care and a description of her feet follows which may aid in identification of this individual, Mrs. Masteller: Present age 39 or 40. At age 11, she contracted polio and has a residual contraction of the toes on her right foot. On her right foot there is an excrescence on the dorsum of the fifth toe and on the plantar surface of the first and fifth metatarsal heads. There is also an excrescence in the plantar medial border of the hallux. On the left foot there is an excrescence on the dorsum of the fifth toe and on the medial plantar border of the hallux. She occasionally has an acute inflammatory (probably arthritic) flare-up of the left ankle joint. Patient has suffered strain on the plantar surface of the mid-tarsal area of the left foot. She is menopausal and has periods of mental depression. Her weight is approximately 140 pounds and she is 5 feet 4 inches tall. She

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may speak of one of her dogs that was killed this past spring. She has no children.

If any podiatrist-chiropodist should treat this patient, would you please immediately contact Dr. D. L. Carroll, 135 Broadway, Hanover, Pennsylvania.

COMMUNICATION FROM THE PROFESSION

To the Editor:

One of the fields neglected in our schools is training in how to present subject matter to an audience. Many of you will likely recall being acutely aware of the lack of dignity and poise on the part of some speakers at local or national meetings of your chiropody association. Some of our men, who were very capable, may now be in other lines of endeavor because of this and "patient approach" insufficiency.

Our students should be taught at least the fundamentals of how to stand, look at the audience (not the floor), enunciate, and how *not* to use his hands. They should use correct English and have an adequate vocabulary without being verbose; should not be self important nor apologetic; should eliminate the use of objectionable slang and avoid profanity or other coarse language.

Some of our students have been trained by special schooling or keen observation in the art of speech and it is readily recognized. The curriculum of chiropody colleges must some day soon include a course of this kind to be counted and graded the same as anatomy. This study could advantageously be included in the Freshman year, and be greatly elaborated to the students' pleasure and benefit. Thus, its use could be carried through the entire course of study. In the event circumstances compelled a student to discontinue chiropody, he would have acquired a valuable asset to apply in whatever field in which he found his niche in life.

One other kindred thought should be in-

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culcated into the minds of all chiropodists, both in practice and in the schools; the obligation of a gentleman to give a speaker respectful attention. He may not be good, may even be dull, but he has been invited to appear and should be accorded the courtesy due him as a guest. We should be silent during his speech, as most speakers have an interesting message to deliver. If anyone is not interested, he should quietly leave the room and allow those who do want to hear, the opportunity to do so.

Last year it was my unhappy experience to try to listen to a brilliant young man addressing a large meeting. He was very modest and self effacing, but he had a message and was forceful and enthusiastic in his presentation. His lecture was almost spoiled for the rest of us by the loud whispering and mumbling of a pair who had preceded him on the program. He had treated their speeches with politeness. Perhaps they were conscious that he was so easily their superior that they so reacted, but it is believed that thoughtless ignorance and sublime egoism made them unaware of the embarrassment they generated in the audience. Such gross discourtesy should be taken care of by the sergeant-at-arms in our gatherings. It is sincerely hoped that all of you will give these thoughts on both items your considered reflection.

Perhaps some of our more experienced men, or one of our brilliant young men in the field, maybe a student, will come forward with a plan to be used in our future training.

Riley C. Armstrong, D.S.C.
Houston, Texas

"So neither ought you attempt to cure the body without the soul; and this is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also. For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body."

Plato

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MEMBERSHIP IS A PRIVILEGE

Committee on State Society Membership

The time is now at hand for the people of our Chiropody Societies to re-evaluate their thinking about membership. As we members know, "Membership is a Privilege," not a privilege for the few but for all thinking chiropodists.

We have reached the point where we can no longer stand still. We must go forward. To do this we need members. We need members who are active. Great progress can be made in public awareness of our profession if we have the membership to back it up. All non-members are to be contacted by the membership committee of each State Society. This contact must be by personal solicitation in each State and Division.

This is the first of a series of communications which will appear in subsequent issues of the *Journal*. Our aim is not for a complete one hundred percent membership of all chiropodists. This cannot be done as there are a few non-members who cannot attain membership because of the manner in which they conduct their practices. These we do not want, but we do want hundred percent membership of all eligible chiropodists. The eligible chiropodist is waiting for your invitation to attend your next meeting. When you point out the obvious advantages of membership, and what a united front has done for the good of the profession, he cannot help but get the idea. Without membership we would have no statutory status; there would be no post-graduate courses; group insurance could not be possible. There would be no public education or information and this would leave us in the dark ages in our relations with lay and medical groups.

If you have questions regarding any phase of membership, get in touch with your Division Membership Chairman immediately. He is ready at all times to help you.

John C. Pankratz, D.S.C.
Meadville, Pa.

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MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.
A.O.P.

Duty is a task we look forward to with distaste, perform with reluctance and brag about afterwards.

Ain't it so?

It's sad to be old and bent but it's worse to be young and broke.

Explaining the difference:

Sam to Jim: "You-all is got religion, I hear."

Jim: "That's right."

Sam: "Goin' to church and all?"

Jim: "Hopes to."

Sam: "Goin' to pass up all your old debts?"

Jim: "Dat ain't religion, boy. Dat's business."

This could only happen in Texas—

"Crop failures? Yes," said the old-timer, "I've seen a few in my day. Like in 1898. The corn crop wasn't nothing at all. We cooked a little for dinner and my father ate 14 acres of corn at one meal."

It was already pretty late when the guest decided that he must go. "Don't bother to see me to the door."

"No bother at all," said his host. "It's a pleasure."

"What do you mean, Son, the world owes you a living? The world was here first."

Proprietor: "In this restaurant when you order a cup of coffee you get the best cup of coffee in the world. When you order an egg you get the freshest egg in the world. When you order . . ."

Customer: "I believe that, all right. I just now ordered a small steak."

No. 175 — Men's
No. 173 — Women's

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Medium— 9-10
Large—11-12

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Medium—6-7
Large—8-9

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When the passer-by saw the little boy sitting on the porch she said, "Hello, George, I understand your father has had a call to become the pastor of a church in another city at a higher salary. Is he going?"

"I don't know," replied George. "Right now he is in his study praying; but Mom, she's upstairs packing up."

When one woman talks it is a monolog. When two women talk it is a catalog.

The golfer's ball had rolled to within inches of a large ant hill. He addressed the ball, took a swing and missed, but tore away half the ant hill. Again he addressed the ball and swung and this time tore away the other half of the hill. When the dust settled two ants emerged. Said one to the other, "Brother, if we want to survive we had better get on the ball."

We named him Theophilus because he's theophilus looking baby we ever saw.

Bennett Cerf

He was short and fat and he wheezed when he talked. "That little corn," he informed the podiatrist, "He says to me this morning, 'Take me up to see the doctor.' 'I can't,' I said, 'I'm too busy.' The little corn never said anything more till just a little while ago. Then he yells at me, 'Darn it!, take me up to the doctor.' So here I am."

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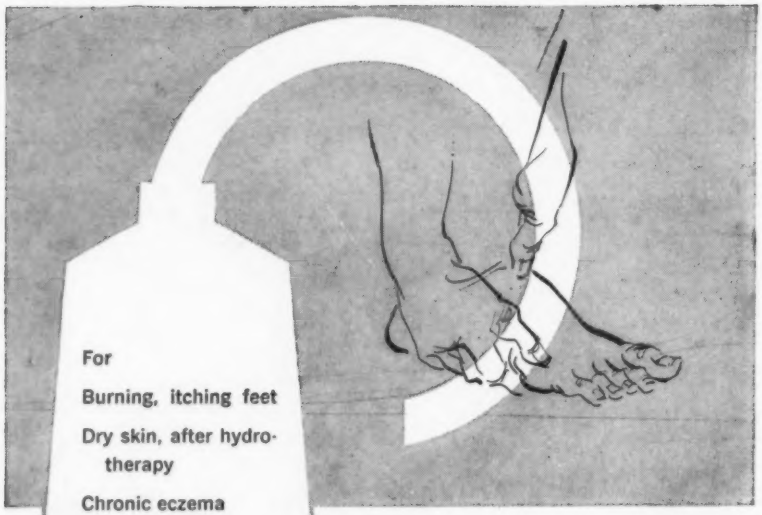

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